COUNTY OF FINANCIAL RESPONSIBILITY
Technical Requirement for CMHSPs
(Revised for FY 07-08)

I. INTRODUCTION.

Lack of statutory clarity with respect to establishing County of Financial Responsibility (COFR) has, in some cases, resulted in delays of appropriate services to consumers, protracted disputes and inconsistency of resolution across the state. This is particularly true for consumers who have never received services from a state operated facility and for whom financial responsibility is thus not addressed directly by Chapter 3 of the Mental Health Code. CMHSPs are statutorily responsible for serving persons 'located' in their jurisdiction even when responsibility for payment is in question. This technical requirement provides a contractual basis for determining County of Financial Responsibility and a process for resolving disputes, regardless of funding source.

This technical requirement is based on the following principles:

- Consumer's have a right to choose where they live, unless restricted by court order.
- Consumer requests for particular providers, regardless of location, must be considered within the person-centered planning process.
- Capitation payments are intended to be a means of funding PIHPs to provide defined benefits to eligible beneficiaries within a system of services. As such, they are not intended as payment for services to any identified individual consumer. Therefore, this Requirement assumes that the receipt of a PEPM payment should not be considered in determining the COFR, nor is specific consideration of the amount of a PEPM a factor in determining the obligation to pay of the COFR.
- Funding for persons served through the Habilitation Services (1915-C) Waiver is intended to support services to named individuals. Thus, such funding should be considered when determining the payment obligation of a COFR when the consumer is served outside the COFR.
- Consumers served according to the terms of this contract must be provided appropriate service without delay resulting from issues of financial responsibility. Community Mental Health Services Programs/Prepaid inpatient Health Plans will act ethically to provide service to consumers meeting eligibility requirements when the COFR is disputed.

II. ESTABLISHING COUNTY OF RESPONSIBILITY

A. **General Rule.** For persons served under the terms of this contract, the financially responsible CMHSP is the one that served them in the county where they last lived independently.

B. **Children.** The COFR will be the county where the child and parents have their primary residence. For temporary and permanent wards of the court (including tribal), the COFR is the county served by the 'court of record', which is where the child was made a ward of the court, or where jurisdiction of the court was transferred upon movement of the child. This court is the 'court of record', which is the 'court of jurisdiction'. For adopted children, once adoption proceedings are completed, the COFR is the county where the adoptive parents have their primary residence.

In the case of divorced parents, the COFR is the county in which the parent with legal and physical custody resides. If the parents have joint legal and physical custody, the COFR is the county of residence of the parent with whom the child lives while attending school.

In the case of a child placed by parents into the custody of a legal guardian with authority to consent, the COFR is the county in which the guardian resides, for the period of the placement. If the parent(s) place the child into the custody of another adult without guardianship, the COFR remains the county where the parent with legal and physical custody resides.

In the case of a voluntary placement of a child by parents into a 24-hour dependent care facility funded by a CMHSP, the COFR is the residence of the parent with legal and physical custody at the time of placement. If the parent(s) move during the placement, upon the children's discharge, the COFR is the county in which the parent with legal and physical custody resides.

A child who is legally emancipated and establishes an independent residence shall be considered a resident of the county where he or she resides. A child who is discharged from a dependent care setting upon reaching age 18 and establishes an independent residence shall be considered a resident of the county of that residence. The General Rule (A above) shall apply to a child who attains adult status when discharged into a new dependent setting, or when that adult chooses to remain in the same dependent setting.

C. **Adults.** Consumers have the right to choose where they live, unless restricted by a court order.

- The choice shall be considered to be the consumer's/guardian's choice when it is not instigated or facilitated by a service manager or provider. Assistance by service managers or providers in a County to notify another County of the consumer's decision to move shall not be determined to be facilitation of the choice.

When a consumer, who is living dependently, chooses to relocate from County A to County B into a dependent living situation, the COFR shall remain the county in which he/she last lived independently.

When a consumer relocates to a dependent setting in County B from an independent setting in County A, County A shall remain the COFR, under any of the following circumstances:

- There is an existing agreement between County A and County B; or
- County A has continued to provide and pay for Mental Health Services; or
- The consumer requests services from County B within 120 days of relocation

When the CMH (including direct or contracted service providers), or DHS office initiates and facilitates the relocation of an adult consumer from County A to County B, County A shall remain the COFR.

When the consumer and/or his/her family wishes to obtain services in county B because services in County A have been determined to be unavailable through a Person-Centered Planning process, County A remains the COFR, with responsibility to authorize and pay for the service, if that service meets eligibility guidelines utilized by County A.

D. **Persons Living in Unlicensed Settings.** Unlicensed settings are generally considered to be independent living. The COFR is the CMHSP serving the county where the residence is located. If the consumer's Level of Care and Intensity of Service required is equivalent to a dependent living setting, the consumer shall be considered to be in dependent care for the purposes of COFR. Equivalency to dependent care shall be established when the individual's Person Centered Plan provides for provision of eight or more hours of specialized services and/or supports in the residence each day.

E. **Provision of Specialized Mental Health Treatment Services to Persons in Nursing Homes.** For provision of OBRA Specialized Services, the COFR is the county in which the nursing home is located. For mental health services which are not specialized, financial responsibility shall be assigned as in A. above.

F. **Jail.** CMHSPs are responsible to provide mental health services to their local county correctional facilities (jails) on the same basis as they provide services to other persons located in their geographical jurisdiction. CMHSPs shall work with Jail personnel to ensure that all reimbursements for health services are pursued, including the county's (not the CMHSP's) responsibility to pay for the costs of health care. If a jailed individual requires State provided inpatient care, the COFR shall be the COFR prior to the individual entering jail. When an individual is released from jail and establishes an independent residence in the county of the jail, the COFR shall be the county in which the residence is located. If the person is released into a dependent setting, the COFR shall be assigned according to the General Rule (A. above).

G. **State Correctional Facility.** When an individual is released, at the end of his/her sentence or on Parole, the COFR shall be the County in which the individual last lived independently prior to entering the correction facility, under the following circumstances:

- The individual has been receiving *specialized* mental health services in Prison, and is determined to have a continued and immediate need for services; or
- The individual requests specialized services, or is involuntarily committed for specialized services within 30 days of release AND
- Meets the eligibility standards for Medicaid or access standards of the CMHSP for GF funded services.

H. **Extent of Financial Liability.** The County which is financially responsible shall pay the full cost of authorized services provided beginning on the date the consumer enters the service system.

It is the responsibility of the serving CMHSP to notify the CMHSP which is, or may be determined under this requirement to be, the COFR that a consumer has initiated a request for service or has been served in a crisis situation. Should the consumer's clinical condition prohibit gathering of information to determine COFR, the COFR's liability shall be limited to 30 days prior to notification by the serving board.

I. **Standard for Response by COFR.** Upon notification that a consumer has requested services outside its jurisdiction, the COFR shall respond to a request by the servicing Program/PHP within the Access Standard timelines for all consumers, as specified in this contract.

J. **PEPM Payments/Medicaid Residency Status.** Serving CMHSPs shall work to change Medicaid Residency Status, and the corresponding PEPM payment, where appropriate. However, Medicaid Residency status, and the PIHP receiving the capitated payment are not determining factors in establishing COFR.

K. **Contractual Arrangements.** Nothing in this Requirement precludes a contractual arrangement between CMHSPs/PIHPs which specifies conditions, standards, or protocols other than those contained in this document, so long as those provisions are consistent with statute and regulation and do not violate provisions found elsewhere in this contract.

III. DISPUTE RESOLUTION

Good faith efforts to resolve disputes, utilizing principles of ethical conduct, and the standards contained in this document must be made prior to initiating this Dispute Resolution process. In order to facilitate informal dispute resolution, each CMHSP/PHP shall provide the name of a responsible contact person to the manager of this contract and to the MACMHB for publication on its website. This good faith effort shall include documented notification of the Executive Director of each CMHSP regarding the known facts and areas of disagreement within two business days of identification of the disagreement.

When formal Dispute Resolution is required, the following process shall be used:

A. **Dispute Resolution Committee.** A COFR Dispute Resolution Committee, consisting of three persons, shall be constituted annually, at the beginning of the fiscal year. One person shall be appointed by DCH and two shall be appointed by the MACMHB. Vacancies on the committee shall be filled within ten days. The Committee shall appoint its chair by consensus. The MACMHB shall appoint a third person who will serve as an alternate representative in cases which would present a conflict of interest for one of the regular representatives.

B. **Initiation of Dispute Resolution.** Either party may initiate dispute resolution by notifying the MACMHB and the DCH Contract Manager identified in this contract in writing.

C. **Fact Finding.** The MACMHB shall notify each Board/PIHP, and all members of the Dispute Resolution Committee, within three business days of receiving notification, that a formal dispute has been received. Each CMHSP shall respond to DCH and the MACMHB, with a copy to the other CMHSP/PIHP, within three business days with a written response, including

- The facts as each entity sees them;
- The rationale for their position, including documents to support their position. In cases involving a child who is a ward of the court, documents must include a court order which establishes the 'court of record/jurisdiction'. Additional documents may be presented at the hearing.

D. **Dispute Resolution Meeting.** The Dispute Resolution Committee will designate a time and place for a resolution meeting, which will be held no later than 30 days following submission of the facts identified in B. above. At this time

- Each CMHSP's (or PIHP's in cases involving Medicaid) designated responsible representative will attend. Each representative will be provided an opportunity to make a verbal presentation regarding the case. Each CMHSP (PIHP) representative must be empowered by its CMHSP (PIHP) to negotiate a settlement of the dispute.
- Should a negotiated settlement not be reached at this meeting, the committee will meet, without others present, to arrive at a decision reached by majority vote of the Resolution Committee.
- The decision shall be reached, and conveyed to the disputing parties, on the day of the meeting.
- A record of each proceeding, including documentation of the facts and the decision, shall be kept by the DCH and by the MACMHB for public review.

IV. DEFINITIONS

- **"Living Independently".** The following factors will be used to determine whether a person is 'living independently':
  - The location in which the person is residing is not transient. For example, residing in a motel or hotel which is rented by the day or week, without intent to remain in the community is not considered 'living independently.' Likewise, placement in a half-way house upon release from jail or prison is not considered 'living independently'. Living in a vehicle is also not considered 'living independently.'
  - Migrant workers shall be considered the responsibility of the CMHSP in which they are housed.
  - The intent of the individual to be part of the community shall be considered. For example, persons who are homeless, living on the street or in a shelter shall be considered part of the community, when the intent of the person is to remain in the community.
  - The location in which the person resided prior to moving into a county was not a boarding school, a facility, or a dependent living setting as defined in the Mental Health Code and utilized in Section 306 thereof.

- **Provider.** As used in Part II, C above, means a provider of specialized behavioral health services or a dependent living site regardless of whether such services are delivered under contract with a CMHSP/PIHP.

BAY-ARENAC BEHAVIORAL HEALTH PIHP
Co-Occurring Disorders – Integrated Dual Disorder Treatment Work Plan
FY 2007 (Revised)

1. Goal: To ensure that all stakeholders are aware of the expanded implementation of the Co-Occurring – Integrated Dual Disorders Treatment Evidence Based Practice across the Affiliation

Year 2

TASK	TARGET DATE	RESPONSIBLE PARTY	OUTCOME
Members of the Riverhaven Coordinating Agency Substance Abuse Advisory Council will receive quarterly reports on implementation of the COD-IDDT	By 12/31/06, 3/31/07, 6/30/07 and 9/31/07	The SA Coordinating Agency Director	Riverhaven CA SA Advisory Council will be knowledgeable of COD-IDDT implementation
SA providers will continue to be encouraged to participate in the Regional Integrated Services WG and Advisory Council	Ongoing	COD-IDDT Coordinator	Integration of the system of care will be expanded across MH and SA provider systems
Informational materials will be used to orient new staff and providers serving persons with co-occurring disorders to COD-IDDT. 1. Self directed learning will be developed for new staff and providers 2. COD-IDDT Coordinator will be available to assist supervisors in orientation of new staff and providers	1/31/07 Ongoing	Regional Integrated Services Work Group, Staff Development and COD-IDDT Coordinator	CMHSP Provider network will be knowledgeable of COD-IDDT
Informational materials will be used to orient new consumers coming into the system of COD-IDDT 1. A brochure outlining the key elements of COD and services available will be developed for consumers	4/31/07	Regional Integrated Services Advisory Council, Staff Development and COD-IDDT Coordinator	Consumers will be knowledgeable of availability of COD services
The Regional Operations Council members will update top administration in each CMHSP on COD-IDDT status	Ongoing	Regional Operations Council members	CMHSP administrators will have understanding of COD-IDDT status

2. Goal: To ensure that the appropriate leadership structure continues to be in place to effectively implement the Co-Occurring Disorders – Integrated Dual Disorders Treatment Evidence Based Practice across the region.

Year 2

TASK	TARGET DATE	RESPONSIBLE PARTY	OUTCOME
COD-IDDT Coordinator will attend monthly CMHSP Implementation Team meetings	Based on CMHSP Monthly meeting schedule	COD-IDDT Coordinator and CMHSP Lead	CMHSP Implementation Teams will receive effective consultation and support

Improving Practices Leadership Team will monitor COD-IDDT implementation across the Affiliation	2nd Thursday of each month	COD-IDDT Coordinator	Effective implementation of COD-IDDT
Regional Operations Council will monitor implementation of COD-IDDT across the Affiliation	4th Friday of each month	Chief of Clinical and Program Operations	Implementation issues are resolved effectively
Regional Leadership Council of affiliate CEOs receives reports on implementation of COD-IDDT across the Affiliation	3rd Friday of each month	Chief of Clinical and Program Operations	CEOs are aware of plans for effective resolution of any implementation issues
PIHP representatives will be involved in the statewide EBP Subcommittee for COD-IDDT and appropriate workgroups	4th Tuesday of each month	COD-IDDT Coordinator, Chief of Clinical and Program Operations	Effective communication between state and PIHP planning for COD-IDDT

3. Goal: To develop the system level building blocks necessary to support and sustain ongoing integrated services to persons with co-occurring disorders

Year 2

TASK	TARGET DATE	RESPONSIBLE PARTY	OUTCOME
The Regional Integrated Services Council will develop a plan to address at least 2 gaps for the Region from the CO-FIT-100 assessment, and the results will be reported to the Improving Practices Leadership Team and Regional Operations Council.	By 12/31/06	Regional Integrated Services Council, COD-IDDT Coordinator	Plans will ensure consistency with the CCISC framework
~~Reevaluation of the progress of system implementation of the Comprehensive Continuous Integrated Systems of Care Model across all CMHSPs in the Affiliation (CO-FIT-100) will be completed~~ **Task Deleted**	~~4th Quarter of FY 2007~~ **Plan to re-administer in 2008**	~~Regional Integrated Services Council, COD-IDDT Coordinator~~	~~Data will be used to track progress to CCISC and identify additional opportunities for improvement~~
Objectives identified from program level assessment (COMPASS) in FY 2006 will be achieved	2nd Quarter of FY 2007	CMHSP Implementation Teams, COD-IDDT Coordinator	CMHSPs will move closer to CCISC ideal
~~Reevaluation of all programs serving persons with severe and persistent mental illness for their capacity to provide services to persons with dual disorders (COMPASS) will be completed.~~ **Task Deleted**	~~3rd Quarter of FY 2007~~ **Plan to re-administer in 2008**	~~CMHSP Implementation Teams, COD-IDDT Coordinator~~	~~Data will be used to identify progress toward CCISC and additional opportunities for improvement~~
The Regional Consensus document on Co-Occurring Psychiatric and Substance Disorders will be updated and approved for implementation across the PIHP Region	2nd Quarter of FY 2007	Regional Integrated Services Council, Regional Leadership Council	CCISC expectations will be consistent with current status and providers will understand next steps to move the system closer to the ideal

Adopted staff competencies will be prioritized for implementation in each CMHSP	2nd Quarter of FY 2007	Regional Integrated Services Council	Staff will be clear about co-occurring capable skills required
CMHSPs will incorporate co-occurring capable skills into clinical competencies	3rd Quarter of FY 2007	Regional Operations Council members, Regional Leadership Council	Evaluations of staff who work with persons with a dual disorder will include competencies related to co-occurring capability
Data on persons diagnosed as having a co-occurring disorder will be reviewed on a quarterly basis and decisions will be made about how to improve accurate identification of SA diagnosis	By 12/31/06, 3/31/07, 6/30/07 and 9/31/07	Regional Integrated Services Workgroup, Improving Practice Leadership Team	Persons with co-occurring disorder who could benefit from COD-IDDT will be more accurately identified
Work with statewide COD-IDDT Evaluation WG to identify appropriate screening and evaluations tools to be used by all providers.	Ongoing until a decision is made	Director of Program Services	PIHP Affiliation will use the same evaluation tool(s) to screen persons to determine if they have a COD

4. Goal: To ensure qualified trained staff are available in the Access Alliance of Michigan, Access Center to screen persons for both mental illness and substance abuse disorders.

Year 2

TASK	TARGET DATE	RESPONSIBLE PARTY	OUTCOME
COD-IDDT Coordinator will review outcome data and results of administration of CODECAT to determine ongoing training needs. Training needs will be prioritized	1st Quarter of FY 2007	COD-IDDT Coordinator and AAM Clinical Services Manager	On-going training needs will be prioritized
IDDT Coordinator (and Specialist in Substance Abuse Services as needed) will provide regular consultation and trainings to Access Staff in prioritized subject areas	Ongoing	COD-IDDT Coordinator	On-going training needs will be addressed

5. Goal: To provide COD-IDDT training for all staff providing treatment and support to persons who have a dual disorder

Year 2

TASK	TARGET DATE	RESPONSIBLE PARTY	OUTCOME
Self Directed Training modules will be developed for prioritized staff competencies adopted by the PIHP Affiliation	2nd 4th Quarter of FY 2007	COD-IDDT Coordinator, Staff Training Specialist and Regional	Staff increase skills in working with persons with COD

		Integrated Services Council	
The Staff Training Plan developed in FY 2006 will be implemented 1. Broad based training for all staff working with persons with COD 2. Intense training for IDDT team related to stages of change and motivational interviewing 3. Train the trainer 4. Clinical Consultation 5. IDDT staff participation in Ohio SAMI COCE training	1st Quarter of FY 2007 ~~2nd~~ **3rd** Quarter of FY 2007 ~~2nd~~ **4th** Quarter of FY 2007 3rd Quarter of FY 2007 4th Quarter of FY 2007	COD-IDDT Coordinator and Staff Training Specialist coordination of Consultant	Increased number of staff with co-occurring capability and co-occurring enhanced level skills
The Regional Integrated Services Work Group will monitor the implementation of the Staff Development plan and report to the Improving Practices Leadership Team on outcomes.	2nd Thursday of each month	Regional Integrated Services Work Group, COD-IDDT Coordinator	Staff COD-IDDT skills will increase
Issues related to staff development requiring administrative input or problem solving will be reported by the Improving Practices Leader to the Regional Operations Council	~~4th~~ **3rd** Friday of each month	Chief of Clinical and Program Operations	Barriers to implementation of COD-IDDT training will be effectively dealt with
The Integrated Services Work Group will review and modify the Staff Development plan as appropriate to ensure the development of COD-IDDT qualified staff to provide integrated services.	At least quarterly review	Regional Integrated Services Work Group	Training plan will effectively address changing needs of staff
~~Each Affiliate CMHSP Integrated Services Implementation Team will have their clinical supervisors and clinical staff who work with persons who have co-occurring disorders complete the CODECAT assessment tool~~ **Task Deleted**	~~4th Quarter of FY 2007~~ **Plan to administer in 2008**	~~Each CMHSP COD-IDDT Implementation Team~~	~~Training needs for staff working with persons with co-occurring disorder will be identified~~

6. Goal: To periodically evaluate the Affiliation fidelity to the COD – IDDT EBP

Year 2

TASK	TARGET DATE	RESPONSIBLE PARTY	OUTCOME
The BABH IDDT team will have a baseline assessment by MiFAST	~~1st 2nd~~ **4th Quarter of FY 2007**	COD-IDDT coordinator will arrange with MiFAST group	Plan will be developed based on identified opportunities for improvement

Affiliate CMHSPs will complete readiness assessment and propose dates they will be ready for a baseline assessment by MiFAST to the COD-IDDT Coordinator	~~1st~~ 2nd 3rd **and 4th Quarter of FY 2007**	IDDT Leaders at each Affiliate CMHSP	Target dates for baseline assessments will be identified.
Affiliate CMHSPs will have a baseline assessment by MiFAST completed	Scheduled **beginning 4th** quarters of FY 2007	COD-IDDT coordinate with MiFAST group	Plans will be developed based on identified opportunities for improvement
Ongoing evaluation of each CMHSP's fidelity to the COD-IDDT EBP will be completed and consultation provided to move all teams to full fidelity	Quarterly after initial baseline assessment	PIHP trained staff who attended the Boyle fidelity assessment training	All CMHSP IDDT teams will reach full fidelity to the COD-IDDT EBP

Michigan Department of Community Health
Mental Health and Substance Abuse Services Administration
Improving Practices Infrastructure Development Grant
Co-occurring Disorder: Integrated Dual Disorders Treatment
Program Narrative
Quarterly Report

Report Period: April 1 – June 30, 2007
PIHP: Kalamazoo CMHSAS dba Southwest Michigan Urban and Rural Consortium (KCMHSAS)
Program Title: Integrated Dual Disorder Treatment (IDDT)
PCA#: 20705 **Contract #:** 20071300 **Federal ID:** 38-3313413
MDCH Specialist: Tison Thomas

1. **Milestones Achieved**

- Completed Fidelity Baseline Review for InterAct ACT Team 3, St. Joseph CMH ACT Team, and Readiness Consultation for Douglass Community Association Targeted Case Management Team
- Completed first half of IDDT Intensive Team Training, including available CEUs for Social Workers, with trainer Deb Myers of Ohio SAMI CCOE.
- Developed and informed stakeholders of Dual Disorder Capability definition and steps for accredited agency providers throughout the PIHP and CA
- Completed Motivational Interviewing Phase 1 and 2 with 9 trainees throughout PIHP participating in process, and peer supervision group begun
- Enhanced peer services in COD by establishing a contracted 501c3 agency, The Recovery Institute, in Kalamazoo

2. **System Transformation/Improving Practices Leadership Team Efforts**

- Added Eric Lake, FPE Coordinator, to IPLT
- Added capability to conduct IPLT and IDDT Program Workgroup via videoconference, which will allow for enhanced participation and lower cost for Affiliate administrative and team leader participation

3. **System's Change PIHP structure**

- KCMHSAS re-organization plan developed which will create a COD Coordinator position as a permanent organizational position, as well as to increase availability of emergency and mobile crisis services offered in the community

4. **Consensus/Charter Document**

- Charter policy completed PIHP policy approval process and signed by Executive Director, Jeff Patton (see attached)

5. **Participation of parties not part of the PIHP/CA**

- Contract between KCMHSAS and the Recovery Institute finalized July 1, 2007, with services to include Certified Peer Support Specialist services to single disorder and COD adults.

Narrative Completed by: Dr. Charles E. Spence, MSW, PhD, Deputy Director of Substance Abuse – 269-553-8152
Budget Completed by: Charlotte Bowser, Senior Financial Analyst – 269-553-8013

- COD-capable services continue at Ministry with Community day shelter, and Michigan Prisoner Reentry Initiative (MPRI)
- Housing Continuum team expanded to include city housing members as well as additional independent living complexes

6. **CO-FIT 100 Completion**

- CO-FIT 100 scheduled to be re-completed by IPLT December 2007, 18 months past most recent administration.

7. **COMPASS Completion**

- COMPASS or TCU Organizational Change Index identified as first required step for Dual Disorder Capability (DDC) by direct operated programs and provider agencies, and form the basis for program-specifie action and training plan development
- COMPASS completed July 2007 by KCMHSAS Developmental Disability program staff
- COMPASS re-administration for KCMHSAS Access, Woodlands (Cass) Behavioral Health, Allegan CMH, St, Joseph CMH, InterAct of Michigan, Douglass Community Association, and Family and Children's Services scheduled Deeember 2007.

8. **Quality Improvement Activities**

- Completion of COCE Teehnical Assistance Process (sereening, prevalence data collection, and welcoming protocols) completed April 2007 with site visit from Deborah Tate of COCE
- Prevalence data for KCMHSAS of for adults of COD or pre-COD at screening 45.77% in 2 month pilot, 16.67% for children during 2 month pilot period
- Use of UNCOPE as screening tool for all presenting adult consumers continued past pilot, and will be incorporated into integrated assessment process currently being piloted

9. **Policies and Proeedures Developed**

- Charter policy developed and approved by Exeeutive Director

10. **IDDT Implementation Teams**

- InterAct ACT Team 3 completed IDDT Fidelity Baseline Review from MiFAST Team, received report with total fidelity rating of 3.1
- St. Joseph Act Team completed IDDT Fidelity Baseline with MiFAST June 26th; anticipating report in July
- Douglass Community Association completed IDDT Readiness Consultation June 29th; anticipating IDDT Fidelity Baseline October 2007

11. **IDDT Team Development**

- Modules 1-4 of 8 of Intensive Team Training for IDDT completed by Deb Myers, Ohio SAMI CCOE, June 14, 15
- Resource Library utilized in curriculum and service development for St, Joe, Douglass, and InterAct IDDT Teams

Narrative Completed by: Dr. Charles E. Spence, MSW, PhD, Deputy Director of Substance Abuse – 269-553-8152
Budget Completed by: Charlotte Bowser, Senior Financial Analyst – 269-553-8013

- 4 members of IDDT Teams in place or being developed in MI Train the Trainer project

12. **Clinical Practice Development**

- Participation of 9 clinicians throughout PIHP in Motivational Interviewing Train the Trainer process, and development of peer supervision group to encourage further skill development
- Continued training on Welcoming practices to Allegan CMH support staff; and Woodlands (Cass) Behavioral Health RTC staff

13. **State Administrative Barriers**

- Requiring by contract the Substance Abuse Licensing AND Accreditation by a national accredited board to become a SUD provider: Accreditation by single or small practices who offer SUD or COD OP services is cost prohibitive, and limits our provider panel to exclusively large, agency-level providers. The Regional Coordinating Agency has considered an application for a waiver from the contract requirements regarding this, and has consulted with Doris Gellert, who reports the ODCP Workforce Development group is addressing this issue in the future
- Lack of clarity about ways to credential, report, and bill for Peer Recovery Services specifically when offered as an integrated service by certified Peer Support Specialists. Currently awaiting technical advisory on Peer Recovery services licensure category

14. **Internal System Barriers**

- Placement of IDDT Program workgroup relative to achieving significant system's change
- Engagement of SUD providers in change effort which has been primarily focused on IDDT implementation
- Coping with relapse or symptom increase of staff involved in co-occurring initiatives who themselves are in recovery

15. **Resource Utilization**

- Grant dollars on target to be fully utilized for project goals by September 30, 2007

16. **Next Quarter Activities**

- Establish incentives for Dual Disorder capability step completion by accredited contract agencies, and possibly direct operated programs
- Add capability to add HH modifiers to eligible services, and HHTG modifiers to 2 eligible IDDT teams (InterAct ACT Team 3 and St, Joseph ACT Team)
- Complete "Stage-Matched Interventions for mental health, SUD, and COD clients" continuing education course through Western Michigan University
- Add COD Competencies to agency-wide job descriptions and performance appraisals through Directive Supervision process
- Complete, in collaboration with other PIHPs, application for second year TA from COCE to focus on peer integration at Access points, and piloting of early stage intervention services
- Enhance participation of stake-holders in action plans re: housing services for COD adults at various stages of treatment (wet, damp, and dry options)
- Complete COMPASS, action, and training plans for contracted agencies that have not yet done so

Narrative Completed by: Dr. Charles E. Spence, MSW, PhD, Deputy Director of Substance Abuse – 269-553-8152
Budget Completed by: Charlotte Bowser, Senior Financial Analyst – 269-553-8013

- Complete Intensive IDDT Team training for InterAct Team 3, and St. Joe ACT Team, by contract with Ohio SAMI CCOE
- Complete Motivational Interviewing orientation to peer staff throughout Kalamazoo

17. Sustainability

- Full Time COD Coordinator position created to include continuation of IDDT and broader COD Capability system's change efforts
- COD-focused Certified Peer Support Specialist position part of in-kind donation to Recovery Institute during incubation phase of 15 months
- PIHP commitment to IDDT with IDDT Program Workgroup, and COD Coordinator functions will continue (although not expand) regardless of MDCH Block Grant funding in future fiscal years

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MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
MENTAL HEALTH AND SUBSTANCE ABUSE ADMINISTRATION

CO-OCCURRING DISORDERS (IDDT)
PROGRAM NARRATIVE
FY 2006/07 3rd QUARTER REPORT

1. Report Period: 4/1/2007-7/31/2007
PIHP: LifeWays
Program Title: CO-OCCURRING DISORDERS PROJECT
PCA#: 06B1MICMHS-03 Contract #: 20061242 Federal ID: 38-2056235

MDCH Specialist: Tison Thomas

Person Completing Report:

Contact Person: Diane Cranston
Address: 1200 North West Avenue, Jackson, MI 49202
Phone: (517) 780-3368 Fax: (517) 789-1276
E-mail: diane.cranston@lifewaysmco.com

2. **Systems Transformation Efforts and Implementation Activities of the Improving Practices Leadership Team (IPLT):**

The IPLT continues to meet for 1.5 hours on a monthly basis to review the organization's progress on the EBPs of FPE, IDDT, MST, and the Medication Algorithm project. The membership includes representation across the continuum of care for the MI Adults, SED children, and individuals with Developmental Disabilities. The membership also includes the Coordinating Agency (Mid South). There has been no change in the IPLT executive team this quarter.

In March 2007 an expanded role of the IPLT was implemented. The IPLT's role was expanded to include an analysis of the effectiveness of the services offered across LifeWays Continuum of Care for each population (MI Adult, SED Child, and DD). For this reason, 3 subcommittees representing each of the population groups were defined and established. The "leaders"/"chairs" of these subcommittees are the IPLT members representing the specific population. The subcommittees include representation from all of LifeWays Service Provider Network, parents, consumers, and community organizations/systems. Based upon their analysis of LifeWays current service array and continuum of care, the subcommittee will make recommendations for system of care enhancements to the IPLT. In turn, the subcommittee leaders and IPLT leader will present the recommendations to LifeWays leadership and Board of Directors. The IPLT bylaws will be revised to include this expanded role. These subcommittee members will become active advocates and system leaders in improving the

recovery culture across the LifeWays Network, in encouraging the paradigm shift in the treatment of individuals with co-occurring disorders, and improving the children's system of care.

The population subcommittees described above began meeting in June 2007. The subcommittees have begun to identify priorities within their population groups and reviewing data regarding their population's services, participation in these services, and costs of these services. The adult subcommittee is meeting twice a month. The children and developmental disabilities subcommittee is meeting once a month. Each meeting is 1.5 hours.

In April 2007, the IPLT Leader/EBP Coordinator, along with the rest of the Co-occurring Disorders Leadership Team (Mid-South's COO, Mid-South's Director of their contracted CDRS, LifeWays Access Center Director) met with Network 180 staff to discuss how they transformed their organization & Network into a co-occurring capable organization and Network.

In April 2007, the IPLT Leader/EBP Coordinator and a LifeWays ACT Team Network Provider, including their Doctor, attended Dr. Mee Lee's Co-occurring Disorders: Dilemmas in Diagnosis and Treatment and the Role of the Physician Training.

In April 2007, the IPLT Leader/EBP Coordinator presented a document describing EBPs, how programs become EBPs and the status of research based programs within the LifeWays Provider Network at LifeWays internal All Agency staff meeting, at the LifeWays Service Provider meeting and at the LifeWays Board of Directors meeting. This document was designed to further educate LifeWays stakeholders regarding EBPs and LifeWays commitment to the implementation of EBPs.

In May 2007, the IPLT Leader/EBP Coordinator and LifeWays internal MST workgroup participated in a 2 hour conference call with the MST services Planning Director located in South Carolina.

In May 2007, the IPLT Leader/EBP Coordinator, Mid-South, and a LifeWays Network Provider attended Phase I of MDCH's Motivational Interviewing Train the Trainer Project. From this attendance, Mid-South identified 1 participant for this project. LifeWays identified 11 participants representing 4 Network Providers for this project.

In June 2007, the IPLT Leader/EBP Coordinator and LifeWays internal MST workgroup met with Jackson County's Juvenile Justice Partners (Director of the Youth Center and Director of Juvenile Probation Officers) to discuss the implementation of the MST program.

In June 2007, the Chief Executive Officers of LifeWays Assertive Community Treatment (ACT) Teams began participating in the IPLT executive committee and have both expressed interest in becoming IDDT Providers.

Due to some of the IPLT members' interest in becoming IDDT providers and MST providers, the IPLT members who are Service Providers can not participate in the development of the MST and IDDT RFPs or discussions with Network 180 about IDDT or the Juvenile Justice Partners about MST. The IPLT leader/EBP Coordinator is sharing general overview statements about the system transformation meetings that are being held.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?**

LifeWays is the PIHP/CMHSP that is responsible for Hillsdale and Jackson Counties. It is a "stand alone" PIHP with no alliance or "hub and spoke" arrangements with other CMHSPs. LifeWays does not provide any direct services. All services are provided through contracted Network Providers. The Substance Abuse Coordinating Agency for Hillsdale and Jackson Counties is Mid-South Substance Abuse Commission. The PIHP and CA are separate entities in Hillsdale and Jackson Counties. In March 2007, Mid South came "to the table" with LifeWays to begin working on co-occurring system transformation both at the point of access and within the substance abuse and mental health treatment programs.

The current Leadership Team for the co-occurring system transformation is Diane Cranston (Clinical Director/IPLT Leader/EBP Coordinator -LifeWays), Niki Feller (Access Center Director-LifeWays), Mary Kronquist (COO- Mid South), and Bob Sweet (Director of CDRS- Mid South's contracted agency for its access center). This Leadership Team has the support of Nancy Miller (CEO-LifeWays), Gary Van Norman (CEO- Mid South), and Dr. Mehta (Medical Director-LifeWays). Nancy Miller receives monthly updates from Diane Cranston. Gary Van Norman receives monthly updates from Mary Kronquist. Dr. Mehta receives monthly updates from Diane Cranston and Niki Feller.

The IPLT's expanded role was defined by Nancy Miller, CEO LifeWays, in order to help facilitate a complete system analysis and change, not just EBP implementation. In June 2007, Nancy Miller, CEO LifeWays facilitated a meeting between LifeWays Board of Directors and Diane Cranston, LifeWays Clinical Director/IPLT Leader/EBP Coordinator to highlight the efforts of the Co-Occurring

System Transformation Leadership Team. This information was well received by the Board Members. The Board Members also offered continued support to the Team's efforts.

In May 2007, Gary VanNorman, CEO Mid-South participated in a meeting with the Co-occurring System Transformation Leadership Team to review the current access system and its co-occurring capabilities and to learn about the Team's activities. He provided his support to the group's efforts.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).**

A consensus document has not been developed regarding the overall system change. The Co-occurring Leadership Team met with Network 180 in April 2007 and was provided with an example of a consensus document to use as a starting point. Additionally, the Leadership Team decided to complete the CO-FIT 100 document and visit Network 180's Access Center prior to completing the consensus document. These activities are scheduled to occur in the 1st two weeks of July 2007. Although the document has yet to be completed, LifeWays and Mid South are in agreement in the development of co-occurring capable points of access and substance abuse and mental health treatment providers. We also agree that mental health should be the lead on servicing the individuals with serious mental illness found on Quadrant IV and II and substance abuse should be the lead on servicing the individuals with substance abuse disorders found on Quadrant I and III.

Currently, Mid South contracts with Bridgeway in Jackson County to provide co-occurring Intensive Outpatient Substance Abuse Services. Mid South states that their Contracted Providers in Jackson County (3 providers) and Hillsdale County (1 provider) are co-occurring capable. Currently, LifeWays does not have any co-occurring capable Providers or individual practitioners.

Concurrently, LifeWays will be working with Mid-South to build a co-occurring capable substance abuse and mental health treatment Provider Network, with the identified first priority as integrated screening, diagnostic and assessment services; and, working with its Network Providers to develop IDDT Teams.

No documents have been developed

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of the PIHP/CA service delivery. Include**

consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.

Consumers, who are also members of the State's Recovery Council participate on the IPLT Executive Committee and IPLT MI-Adult Subcommittee, expressed support of LifeWays and Mid-South's concurrent approach to the development of a co-occurring capable service delivery system and the development of IDDT teams. When Mid South and LifeWays develop a consensus document, this consensus document will be shared with the IPLT Executive Committee and the IPLT MI-Adult Subcommittee. It will also be shared with Foote Hospital staff, Center for Family Health staff, Michigan Prisoner Re-entry Initiative-Mental Health Specialty Program staff, Adult Jail Diversion Program staff, Human Services Network members (multi-collaborative body in Hillsdale County) , Human Services Coordinating Alliance members (multi-collaborative body in Jackson County), LifeWays Board of Directors, and Mid-South's Board of Directors. The target date for completion of the development of a consensus document is the middle of August 2007 so that it can be shared with the HSN and HSCA in August 2007.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?**

The CO-FIT 100 was scheduled to be completed in a joint meeting between Diane Cranston, LifeWays and Mary Kronquist, Mid-South in June 2007; however, due to an illness, this meeting has been rescheduled for July 2, 2007.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?**

The COMPASS has not been implemented yet. Mid-South and LifeWays will be discussing how to distribute and implement this with their Providers in the month of July. The plan is to have this completed by the end of August with Minkoff and Kline coming in to consult with LifeWays and Mid-South in September on the development of an Action Plan.

8. **How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

LifeWays' 2 Quality Improvement Specialists have been assigned to the IPLT and the MI Adult Subcommittee. As previously stated members of the MI Adult Subcommittee will be included as part of the Co-Occurring Leadership Team once the IDDT Providers are chosen. No targets or indicators have been chosen yet. Currently, LifeWays data systems has not accurately recorded the number of individuals in the CA or PIHP system with co-occurring disorders. Processes will be put into place to capture this data in the upcoming quarter. A consensus priority document has not been developed.

8. **What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

No policies and/or procedures have been developed at this time. The Co-occurring Leadership Team has identified the development of a universal screening tool and assessment tool as a priority. Thus, the first policies and procedures will focus on an integrated screening, diagnostic and assessment process that includes this tool.

9. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.**

The IDDT Providers have not been chosen. LifeWays will be developing and distributing the RFP for IDDT services in the next quarter. The ACT Providers will be the only eligible providers to bid for the service because the IDDT services will be integrated into the ACT teams. The CEOs of the ACT Providers have expressed an interest in doing IDDT. In May 2007, individuals from the ACT Providers were nominated as participants in the MDCH Motivational Interviewing Train the Trainer Project. These individuals will then assist the Network Providers in becoming co-occurring capable. It is expected that the IDDT Teams will become "experts" in delivering co-occurring capable services and provide technical assistance to the rest of the Provider Network.

10. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

The following activities have taken place regarding IDDT team development:

- Commitment from the CEOs regarding their interest in the development of IDDT teams.

- In April 2007, 1 of LifeWays ACT Teams, including the ACT Team Doctor, attended Dr. Mee Lee's Co-Occurring Disorders: Clinical Dilemmas in Diagnosis and Treatment and the Role of the Physician Training

- In May 2007, 1 of LifeWays ACT Teams Administrators attended the Directors meeting for the MDCH Motivational Interviewing Train the Trainer Project

- In May 2007, 1 of LifeWays ACT Team Administrators and Supervisors attended the ACT conference sessions on Integrating IDDT into ACT teams, and EBP in the ACT teams

The fidelity scales have not been used yet. The plan is to use the scales in the development of the IDDT RFP. Network 180 will provide guidance on this activity. LifeWays is not ready to schedule a MiFAST fidelity review. Data collection and performance improvement activities are not yet in place for the IDDT team.

No assistance from national consultants was provided this quarter. The plan is for the IDDT providers to be chosen in the 4th quarter with consultation from Network 180 and Patrick Boyle on the development of the RFP and planning work for the implementation of the IDDT teams.

11. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?**

The training program has not been developed yet. The Leadership Team's preliminary discussions regarding training have included the use of Mid-South's substance abuse staff to train LifeWays clinical staff and vice versa. Also, the utilization of COD:IDDT training funds to train individuals from both Provider Networks. LifeWays will contact Network 180 and other "exemplary" Co-occurring sites to get examples for the design of their training program. The training

program will be part of the Overall Action Plan that will be designed based upon consultation with Minkoff and Kline.

12. **What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?**

At this point, no barriers have been identified. The MDCH Specialist has been very helpful, encouraging and supportive. It would be helpful if the State would consider allowing the PIHPs to "carry over" unused grant funds into the 2nd year of the grant, like was allowed with FPE for the fiscal 06/07.

13. **What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?**

In this quarter, the biggest internal administrative barrier continued to be filling the EBP Coordinator position. In June 2007, we interviewed another group of candidates and offered the position to a candidate who accepted it. She is scheduled to begin work on July 9, 2007. Her arrival will help "fast track" the EBPs that have moved slowly due to the Clinical Director's 3 major functions as the organization's Clinical Director, EBP Coordinator, and IPLT Leader.

At this time, the Co-Occurring Leadership Team will be seeking ongoing technical assistance from Network 180 and Venture in all areas, starting with co-occurring screening, diagnosis and assessment and the development of an IDDT RFP.

14. **If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?**

Project implementation has been slow; however, with the hiring of the new EBP Coordinator beginning 7/9/07, the project is expected to move forward more rapidly. It is expected that some of the allocated resources for fiscal year 2006/2007 will be carried over into fiscal year 2007/2008 due to the challenges in identifying and hiring a new EBP. The national consultant visits that were planned for the 4th quarter will not occur until the 1st quarter of 2007/2008. No amendment will be requested at this time; however, LifeWays will submit a request to "carry over" unused dollars into Year 2 of the COD: IDDT grant period.

15. **What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.**

- Develop a consensus agreement document with Mid-South that includes the vision for an integrated screening, diagnostic, assessment services
- Develop the screening, diagnostic, and assessment tools
- Train the Access Center on these documents
- Complete the GOI, COMPASS Documents
- Develop an Action Plan that includes a Training Program
- Write and issue the RFP for the IDDT Teams
- Select IDDT Providers

At this time, in the coming quarter, project "Training funds" will be used to fund the attendance of participants in Phase II of the Motivational Interviewing Train the Trainer Project; attendance at the Substance Abuse Conference in September 2007; attendance at the MACHMB Conference in September; attendance at the Seeking Safety EBP training in August 2007; and consultation with Patrick Boyle to work with LifeWays in developing the IDDT RFP and meeting with the chosen IDDT Providers.

16. **What actions are being taken by LifeWays to sustain this initiative after the block grant period ends?**

The IDDT program will be integrated into LifeWays service array for adults with mental illness. It will be sustained through LifeWays Medicaid and General Fund dollars. It is also expected that LifeWays and Mid-South will develop a funding agreement to share costs for individuals with no insurance.

Agency:
Project title: **MCCMH IDDT Implementation**
Contract number: **20071298-1**
Project number: **20707**
Time period covered: **April 1, 2007 to June 30, 2007**
MDCH Specialists: **Tison Thomas, Patty Degnan**

1. Include the project title, contract number, project number, time period covered, and MDCH Specialist's name at the top of the report. At the bottom of the report, please include the person's name that completed the report, as well as contact information for that person.

2. Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.
   a. The IPLT oversees the implementation of the IDDT COD initiative through regular meetings and sub-committee activity.
   b. The IPLT provides direction regarding other practice transformations, such as incorporation of recovery, coordination with physical health care, self-determination policy and practices, and preparation for dialectical behavior therapy.
   c. The IPLT assists with the selection and preparation of grant proposals (e.g., the DCH Block Grants) for the implementation of particular clinical practices and programs.
   d. The IPLT has supported the involvement of MCCMH in the screening and engagement project spearheaded by Network 180 with a COCE grant.
   e. A sub-group of program representatives of organizations implementing the IDDT COD EBP "Toolkit" model has begun to meet. As additional providers begin actual implementation, representatives from those programs will be added to the group.

3. Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?
   a. Macomb County Community Mental Health (MCCMH) is a single-county, stand-alone PIHP that maintains a panel of providers who deliver specialty mental health services and supports. Some providers are contractual but MCCMH also delivers some services through a staff model. Macomb County Office of Substance Abuse (MCOSA) has been part of MCCMH since the mid-1970's and maintains a panel of contract providers who deliver substance use disorder services. Some of the providers on the MCOSA panel are also part of the MCCMH behavioral health panel.
   b. The IPLT membership includes the Director of Behavioral Health, the Medical Director, and the Deputy Director of MCOSA, as well as quality improvement staff, consumers and family members, and advocates.
   c. The IPLT makes recommendations to the MCCMH Executive Staff, which provides final approval for important actions.

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4. Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).
   a. MCCMH has developed and disseminated an Executive Directive describing the core values and principles of the implementation of the COD. See attached.
   b. MCCMH continues to revise PIHP policies on an on-going basis to include the COD initiative. PIHP policies are incorporated by reference in all contracts with members of the provider panels.

5. Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.
   a. Consumer and family stakeholders are part of the IPLT which is overseeing the implementation of the EBP.
   b. Reports are provided to the MCCMH Citizens Advisory Committee as needed.
   c. MCCMH is implementing an outreach team for chronically homeless individuals under a separate DCH block grant. This outreach team will meet many individuals with COD issues and services needs. Discussions with members of the Macomb County Homeless Coalition regarding the outreach team provide regular opportunities to update the coalition members regarding the COD EBP implementation. The outreach team will work in settings that is already being served by the FQHC "look-alike" in Macomb County. This provides additional opportunities for coordination of care with physical health.
   d. MCCMH is an active member of the Macomb MPRI Steering Committee and is contracted with Ufeways to provide services for offenders who have received mental health services in prison as they re-enter the community. The number of individuals re-entering the Macomb community who need both mental health and substance use disorder service is high. The implementation of the COD initiative prepares MCCMH providers to deliver services needed by this populations.

6. Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?
   a. The CO_FIT 100 was distributed to the IPLT and formed the basis for early discussions regarding processes of implementation.

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b. The CO-FIT 100 will be completed formerly in the next quarter.

7. How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DOC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?
   a. Programs implementing the IDDT-COD SAMHSA toolkit have completed the COMPASS and CODECAT. The results form the basis for on-going meetings with the providers as they implement COD services.
   b. Programs on the MCOSA panel received the COMPASS and CODECAT and are completing the documents. Results will be collected through the MCOSA staff and analyzed by the Director of Behavioral Health.

8. How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?
   a. Quality Improvement staff from MCCMH and MCOSA participate regularly in the IPLT. A member of the MCCMH BH QI staff is a member of the MI-FAST group.
   b. The MCCMH QI process will assist in implementing indicators chosen through the IPLT as COD services are implemented.

9. What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the' process of development and submit any products.
   a. MCCMH implemented a new Electronic Medical Record (EMR) on 10/01/06. The EMR contains a screening instrument (the UNCOPE) and materials for assessing substance dependence/substance abuse issues. Its physical health screen also includes questions regarding substance use experiences which are completed by consumers when they complete the health screen. Implementation of the EMR has included implementation of regular screening for substance use issues and follow-up assessment processes.
   b. MCCMH Access Center is the initial central point-of-contact for all new consumers who do not present directly to emergency' rooms of hospitals under contract to MCCMH. The Access Center uses a telephonic screen to determine urgency of need and sets up the initial face-ta-face assessments for consumers who appear to be eligible for CMH services on initial information. The MCCMH Access Center has

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participated with other Boards in the COCE grant managed by Network 180 regarding processes of screening, welcoming, and transfer for services. MCCMH Access Center routinely check with consumers several days after their initial contact to ensure coordination of care and to resolve potential barriers to service that may have arisen after the initial contact. The substance abuse access point, CARE, also participated in the screening pilot. This provided additional feedback to the process.

10. If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.
    a. Four teams have been identified to implement the IDDT-EBP COD SAMHSA "toolkit" model. One team is part of an integrated inpatient-outpatient system of care under contract to the Board. A second team has been developed by a large contract provider, who also provides clubhouse services, residential services, outpatient services, and is simultaneously working on an outreach team for the chronically homeless in Macomb County. The third and fourth teams implementing the IDDT-COD are directly operated by the MCCMH Board as part of the continuum of care. One of the teams is an ACT team and the other is part of the community-based intensive case management unit for adults with SMI. These teams were identified to implement the IDDT in order to provide a variety of learning experiences to MCCMH regarding how COD services can be implemented throughout all relevant providers on its panels.
    b. Each of the teams leading the implementation of COD services are embedded in a larger provider continuum. Each implementation will set the stage for wider implementation of COD services by inpatient, residential, and outpatient service providers.

11. What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IOOT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?
    a. The first and second IDDT teams have started operation. The Fidelity Scales have been used as the bases for planning sessions leading to implementation. Therefore, the teams have been constructed with the Fidelity Scales in mind, although they are not likely to be fully in place until each teams has reached "critical mass" during the implementation process.

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b. The third team (ACT-based) has identified current ACT members who exhibit cooccurring disorders and have made preliminary judgements about their current stage of change. The ACT teams also participated in an ACT fidelity assessment from out-of-state reviewers during this quarter. Recommendations from this assessment will assist in preparing the team for implementation of the SAMHSA toolkit and for fidelity assessment of the IDDT EBP.
c. The fourth team has not yet begun operation. Casemanagers on the team are currently serving large numbers of consumers. Further actions to reduce caseload size to the lower ratio expected in the toolkit model will be necessary before full implementation is possible.

12. What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?
    a. The third and fourth teams have continued and completed additional training this quarter regarding substance abuse issues and intervention. Topics were identified through general planning discussions and through the use of the CODECAT. The staff who are on these teams are existing staff rather than staff hired specifically for their pre-existing expertise and experience with substance abuse and COD issues. Topics this quarter have included training regarding groups in substance use disorder services, ethics and legal issues, preparation for interfacing with self-help organizations, and additional exposure to motivational interviewing.
    b. MCCMH has provided consecutive levels of training regarding motivational interviewing with Michael Clark. Candidates for participation in the train-the-trainer initiative with Michael are being recruited from among those who have completed these local training sessions. They will join the state-wide project at a later stage.

13. What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?
    a. Components of the recent licensing law for social workers continue to pose problems regarding the credentialing of staff for provision of specific services and the

appropriate use of billing codes for those services.

b. The Office of Drug Control Policy implementation the motivational interviewing train-the-trainer project does not consistently match expectations of the similar project for staff in the behavioral health organizations. Improved coordination at the state planning level is needed.
c. The Office of Drug Control Policy implementation of the AAR (AMS) is changing the role of the initial access point for substance use disorder services among coordinating agencies. Integration of substance abuse and behavioral health access systems will be more complicated until the transition is complete.
d. Preparation for COD services by an existing ACT service team builds on the fidelity of the implementation of the ACT EBP. A review of ACT fidelity was conducted this quarter with staff from the ACT Center of Indiana. The final reports have been received and are being integrated by the IPLT to produce recommendations for improvement.
e. Disputes regarding PA2 funds for the substance abuse coordinating agency is leading to reduced service availability and uncertainty regarding continuing availability of different levels of care for substance use disorders. This may complicate the treatment of persons with cooccurring disorders. Resolution of the dispute and stabilization of that funding stream for subsequent years would facilitate planning activities.

in credentialing of substance use disorder service workers and programs will increase disparities between MCOSA and MCCMH contract expectations and allowances. Improved coordination of projects between DCH and the ODCP are recommended, especially in regard to the.

14. What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?
    a. MCCMH continued to participate in the COCE-sponsored, Network 180 managed consultation and technical assistance regarding initial screening process and welcoming at point of initial contacts with MCCMH.
    b. Preparation for COD services by clinical teams employed directly by MCCMH had to address existing skills sets of the staff. A training series was devised and delivered not only to staff implementing the COD "toolkit" model but also to staff who will implement Dual Disorder Enhanced services in outpatient settings serving Adults with Serious Mental Illness.
    c. Caseload size for casemanagers in the fourth "toolkit" team continues to larger than

recommended. Analyses of case management needs among MCCMH consumers and appropriate staffing levels for MCCMH provider agencies have begun but are not yet complete. Planning for modification of case management resources continues but is being influenced by budgetary considerations associated with re-basing and the general state budget instability.

15. If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?
    a. The implementation continues to take more time that originally expected. Continuing difficulties with policy direction, budgetary negotiations, and similar state-level issues continue to slow development. Amendments to extend time for implementation should be explored.

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.
    a. The initial teams will continue to expand and stabilize their services.
    b. Both initial teams will be training peer support specialists for inclusion onto the teams.
    c. The ACT-based team will expand the use of IDDT services with current members and will begin to consider changes bases on the the ACT fidelity assessment that was conducted in June.
    d. Planning for changes in case management capacity and for reduction of caseloads to the size recommended in the "toolkit" will continue so that the fourth team can begin operation.
    e. Preparation for fidelity assessment from the MI-FAST project will take place. MI-FAST has been asked to schedule the assessments as soon as the statewide schedule permits. This is likely to occur in the first month of the current fiscal year. Meetings with internal providers will use the fidelity assessment tools in the IDDT EBP as the basis of internal planning. Coordination of preparatory activities with MI-FAST will also take place.

17. What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?
    a. The teams implementing COD will be using capitation resources for service provision. This process does not depend on grant status and will continue after the end of the grant period.
    b. The effect of COD services from the teams will continue to spread to other service

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programs within the same providers.

c. Access systems will continue to implement and perfect screening and assessment activities for COD.

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Michigan Department of Community Health
Mental Health and Substance Abuse Administration
Improving Practices Infrastructure Development Block Grant
Integrated Dual Disorders Treatment
Program Narrative
Quarterly Report

1. **Report Period:** April 1, 2007- June 30, 2007
PIHP: Lakeshore Behavioral Health Alliance
Program Title: Integrated Dual Disorders Treatment
Executive Director: James Elwell
Address: 376 Apple Ave., Muskegon, Michigan 49442
Contact Person: Teri Smith
Phone: (231) 724-4592, Fax: (231) 724-6042
E-mail: smitht@cmhs.co.muskegon.mi.us
PCA #20708: Contract # 20061244
Federal ID: 38-6006063

2. **Briefly summarized the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.**

During the third quarter of FY06/07, the Affiliation Improving Practices Leadership Team (IPLT) met on a monthly basis. The team focused much of its efforts on assuring the availability of FY07/08 funding to sustain four evidence-based practices, assessing the capacity of the PIHP to support consumers in recovery, and overseeing the drafting, ranking, and submission of FY07/08 Mental Health Block Grant proposals.

Findings of the ROSI Consumer Self Report Survey indicated that the PIHP has established a solid foundation for supporting persons in recovery, thanks in large part to the extensive staff training in WRAP/Recovery, periodic presentations to staff by our certified WRAP facilitators, and the inclusion of peer support specialists in our workforce. Based on the survey results, however, both Ottawa and Muskegon CMHs will focus on improving their ability to help consumers obtain affordable housing and reliable transportation, advance their educations, and find and retain competitive employment.

Seven FY07/08 Mental Health Block Grant proposals were drafted and submitted including ones for enhancing Co-Occurring Disorders/IDDT and Family Psychoeducation, implementing the Evidence-Based Practice Supported Employment model, and establishing a consumer-run recovery cooperative in Muskegon County.

IPLT leadership and IDDT implementation coordinators from both CMHs presented a proposal to the Lakeshore Behavioral Health Affiliation Council in May for the development of Integrated Dual Disorder Treatment teams in both counties and received solid support from PIHP Senior Management for moving forward on this initiative.

The IPLT continued to review and discuss "Tools for Transition" articles from the *Behavioral Health Care Journal.* Of particular interest were articles about the use of employee performance evaluations as a tool for organizational change and the value of peer employees in helping an agency become recovery based.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership? Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).**

Both counties continue to work with stakeholders and substance abuse providers in their area. Staffing changes during the past quarter at Ottawa CMH will slow the IDDT development. Both the executive director and the program director left the agency this past quarter. Further development or staffing changes will have to wait until new leadership is hired.

A further CCISC #7 document has been accepted by the steering committee and stakeholder work group, and is close to being presented to the Affiliate Council of the PIHP for approval. (See attached).

3. **Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stake holders, primary health care and emergency rooms, criminal justice, and homeless services, child welfare, etc.**

In Muskegon Co., CMH staff are meeting regularly with two work groups:

a. The Inner-agency Jail/corrections work group has been meeting for over a year to develop improved services for the mentally ill and dually diagnosed consumers. Current priority of an additional work group includes the

design of a screening—assessment program for citizens in contact with police and exhibiting symptoms of illness. Muskegon Co officials would like to build a new jail and have asked CMH to assist with the design of improved services.

b. Muskegon CMH staff continue to meet monthly with a community Substance Abuse Treatment Collaborative. Several items are priorities for discussion: the need for detox services, and the need for half-way house programming. The committee is a forum to exchange programming information and discuss methods to improve service and communication. At the June Collaborative meeting the CCISC was reviewed by attending members. All expressed enthusiasm for continued work on this document and ideals. A further work group meeting will be held in August.

4. **Has a consensus document been developed regarding the overall system change?**

Further work on the CCISC document took place with draft #7 being written by the steering committee and an Ottawa County work group. In Muskegon, several agencies have new representatives just learning the principles. The June the Muskegon Substance Abuse Collaborative meeting, had a review of the #7 document draft, and expressed enthusiasm for working on the stated goals. A consensus work group meeting will be conducted in August in Muskegon.

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of PHIP/CA service delivery.**

Both Ottawa and Muskegon staff continue to work with interagency jail diversion work groups, housing groups and other organizations as needed. A nurse from the Muskegon County Jail expressed interest in an out-of-state training-certification course for jail nurses for treatment of dual inmates. Muskegon CMH offered to assist with this training and would be interested in her sharing information with additional jail staff in both counties.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?**

Ottawa County staff and partners completed the CO-FIT in June. An action plan will be developed from the findings. Muskegon will conduct a CO-FIT in the fall, after the work group is better established. (See attached Ottawa CO-FIT)

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is**

the status of action plan development and progress for participating program? What plans are there for widening program participation?

The COMPASS was conducted by the two county clinical staff during the past year, and action plans have been developed based on outcomes. The action plan for the final two quarters is attached.

8. **How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question # 4 above?**

Quality Improvement activities in Muskegon County include:

- Two case management teams completed the CODE CAT during June and discussed treatment planning and program changes in Muskegon. Most staff indicated that the philosophy and values are positive and training has been helpful.

- Staff from both counties indicate the need for further work on staging and treatment planning. (See attached CODE CAT analysis from the two counties).

- QI indicators will be further developed as each county moves beyond agency COD capability to having IDDT teams working and a treatment continuum developed. IS problems with a new AVATAR system has slowed some initiatives.

9. **What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

The steering committee has targeted administrative policies and procedures to be completed during this next quarter. In both counties program descriptions are being revised to reflect welcoming of individuals with co-occurring disorders. The CMHOC policy on alcohol and drug abuse is scheduled to be revised by the CMHOC IDDT steering committee. Computer problems with Avatar have slowed the implementation on the PIHP improved assessment tool. Clinical leaders in Muskegon are considering the implementation of screening questions as a part of integrated treatment planning and program development. A work group in Muskegon County has been working on defining staff competence and use of HH codes. It is hoped that by the end of the fiscal year a treatment continuum and

staff knowledge of staging will be ready to feel confident in using the appropriate treatment steps and codes.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.**

    On May 3, 2007, the PIHP Affiliate Council approved the further development of treatment programs and IDDT teams for each county. Unfortunately, the director and program manager of Ottawa CMH left the agency in May so the development of a team in Ottawa is slowed. The Muskegon work group has decided to move forward and team members have been identified. The following team members have started to meet and set priorities for team start-up:

Administrator Leader	Teri Smith, BSW, MPA
Clinical Leader	Sara Boersma MSW
Substance Abuse Specialist	Bob Bultema, BSW, CAC
Outreach, Support Staff:	Harold Thomas, CAC
	Kara Jaekle, Support Coordinator Assistant
Peer Specialist – Dual Recovery:	Gerald and Curt

    A work group continues to meet in Muskegon to develop a persuasion group to start in August. The clinical work group—IDDT staff are planning a trip to Kalamazoo Inter-Act to sit in on active groups there and ask questions about their integrated services. The meeting is planned for July 31.

11. What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?
    In the next quarter, Muskegon staff hopes to be ready for a pre-readiness review. A Mi Fast Fidelity review will not be possible until 2008, when the team has a period of working together and serving consumers identified.

12. **What activities have been undertaken regarding clinical practices development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g.,**

assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?

The attached CODECAT evaluation provides information regarding staff needs for further training. The block grant request for 2007-8 designates funds for further staff capability training and the development of skills for the IDDT team. The steering committee focused further training ideas on skill development and treatment development.

13. **What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?**

Continued support and training from the state will be very helpful. We look forward to the Patrick Boyle supervisory training. Training to further staff competency in treating co-occurring consumers would be welcomed. A workgroup at Muskegon is evaluating staff competency, and development of appropriate coding to reflect work done with dual clients. Muskegon staff recently received the Integrated Treatment license and added Peer Recovery and Support to its license as well. We also supported a dual consumer in attending the State Peer Advocacy training. Some confusion does exist between the CA and CMH with qualifications, coding and authorization. We will continue to work with the State on clarification.

14. **What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?**

Several issues remain constant: If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?

Both CMHs support the development of enhanced services, but struggle with the capacity demands which already stress staff time and finances. These new changes create multiple competing demands for both clinical and administrative energies. Resources are being fully utilized. In Muskegon Co., facility issues will be a barrier to development of expanded programming. Office space and appropriate room to expand groups is a challenge.

15. **If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be filed?**

It is expected that all of the resources will be utilized.

16. **What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement?**

Please see last two quarters work plan. Continued training on Motivational Interviewing and stage of change treatment design will be the funding priority. In Muskegon County, the development of the IDDT team is a priority. Team discussions on eligibility, capacity, programming, etc. are just beginning.

17. **What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?**

As an IDDT team and staff become more competent, it will be expected that treatment services will continue as an integrated part of services. The PIHP has also applied for another Mental Health Block Grant to facilitate expansion of services for persons with co-occurring disorders.

ATTACHMENT C – CO-OCCURRING DISORDERS NARRATIVE REPORTING REQUIREMENTS

A program narrative report must be submitted quarterly. Reports are due 30 days following the end of each quarter. (For the first three quarters, reports are due January 31, April 30, and July 31, 2007. The **final report*** must address the entire fiscal year and is due October 31, 2007). The format shown below should be used for all narrative reports.

* **FINAL REPORT**: The format shown below must be used to summarize the activities during the entire project period.

Michigan Department of Community Health
Mental Health and Substance Abuse Administration
Co-occurring Disorder: Integrated Dual Disorders Treatment Training Grant
Performance/Progress Reporting Requirements
Quarterly Report

Report Period: April – June 2007
PIHP: Network180
Program Title: Integrated Dual Disorders Treatment Training Grant
Executive Director: Paul Ippel
Address: 728 Fuller NE Grand Rapids, MI 49503
Contact Person : Jane Konyndyk
Phone: 336-3765 Fax: 336-3593 E-mail: janek@newtork180.org
PCA # 20719 Contract # 20061245 Federal ID: 38-6004862

IDDT Quarterly Report

2. Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.

Network180 has continued consultation with Dr. Ken Minkoff and Dr. Chris Cline. The structures created to support the development and implementation of CCISC remain in active and involved. These include the CCISC Leadership Team, the CCISC Team/Trainers, and the CCISC Curriculum Group.

The Improving Practices Leadership Team (IPLT) continues to meet on a monthly basis, with the exception of the month of April. The meeting was cancelled due to scheduling conflicts. The IPLT has been following the Action Plan that was developed in 2006 and has focused on the following activities:

- Review of evidence based practice (EBP) currently in use in our system. During the past quarter, the following practices were reviewed:
  - Consumer Involvement-four peer specialists working in the Network180 system presented a panel discussion that focused on the following topics:

- Financial barriers- the difficulties related to the transition to full time employment
- Social barriers-specialists working part-time identified the difficulties related to their status as a peer support some days of the week, and a consumer the remainder of the week
- Recommendations-both full and part-time positions need to be made available, opportunities for advancement from the peer specialist position need to be created

o Teen Screen

- The Improving Practices Leadership Team has not confined its review to established EBPs, but is also reviewing emerging practices that are not researched based.

- The IPLT Data Team, which is made up of Network180 and provider staff, are in the process of reviewing the data that is available from the Network180 system and provider system regarding evidence based practices.

- The Improving Practices Leadership Team received regular reports from the Recovery Council, from the Network180 Research Committee, and from the MiFAST Representative who sits on the Improving Practices Leadership Team.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?**

Network180 is the PIHP, the CMH, and the CA. The CCISC Leadership Team is made up of the Executive Directors of a number of mental health and substance abuse providers for adults and children's services. The role of this group is to guide and lead the CCISC implementation in the Network180 provider system.

Mike Reagan	President, Proaction
Jack Greenfield	President, Arbor Circle Corporation
Greg Dziadosz	President, Touchstone innovare
Sharon Loughridge	President, DA Blodgett
Al Jansen	Pine Rest Christian Mental Health Services
Tom Moore	Clinical Supervisor, Life Guidance Services
George Tyndall	Clinical Supervisor, Bethany Christian Services

Network180 has encouraged the involvement of Medical Directors and psychiatric staff in the CCISC initiative. The Medical Directors and psychiatrists have met with Dr. Minkoff and Dr. Cline on each of their visits to Network180.

The Improving Practices Leadership Team has Network180 representation from the MISUD Adult Team and the Children's Team. There are also representatives from the mental health and substance use disorder treatment systems, adult and children.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities** that have been adopted (e.g., welcoming, screening, data collection, etc.).

Network180 has developed the CCISC consensus document 2007. This document has been signed by all of our mental health and substance abuse providers of adult and children's services.

In 2006, the system priorities for Network180 included welcoming, screening, and data collection. A process improvement team was convened to address each of these areas. A collaboration between the Screening and Data PITS lead to the development of the COD Data Project. This project is designed to determine the prevalence of diagnosed COD, as well as Pre COD. Pre COD has been defined as the presence of indicators that fall short of meeting the DSM IV criteria for a mental health and a substance use disorder. It was determined that this information was valuable to service planning, client placement/referral and clinical interventions. See # 8.

The Consensus Document outlines specific provider activities that are eligible for an incentive. In the 4th Quarter, providers will submit documentation if their performance for review.

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

Network180 is committed to collaboration with community providers and partners. Network180 staff members participate in the following collaboratives:

- Vision to End Homelessness-
- StreetReach Community Advisory Team-housing, physical health, police department, homeless services-monthly meeting
- StreetReach Stakeholder Group- housing, shelter system, police department, community health centers, DHS, employment services-February 2007
- Kent County Family and Children's Coordinating Council-DHS, service providers
- Prostitution Roundtable-61st District Court, Social Work and Police Partnership (SWAPP), service providers, housing

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?**

Network180 completed the CO-FIT in September 2006. Network180 administrative staff, Access Center staff, and Contract Managers from the MISUD Team and the Children's Team participated. In discussion with the CCISC Leadership Team, it was determined that before we developed any process improvement teams from the CO-FIT, that we should develop a long-range plan for CCISC. The CCISC Leadership Team held two half-day planning sessions and developed three goals with timelines.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of action plan development and progress for participating programs? What plans are there for widening program participation?**

The CCISC Consensus Document 2007 provides for an incentive for completion of the COMPASS on an annual basis, and development of an Action Plan based on the COMPASS. The providers conduct the COMPASS independently; Network180 staff members are involved by invitation only. Network180 staff members are available for consultation regarding the administration of the COMPASS and for technical assistance in action plan development/implementation. Network180 does not collect the results of the COMPASS. Network180 convenes a meeting approximately twice a year of all of the Network180 providers. Each provider offers a general description of their experience with the COMPASS and describes progress on the Action Plan. Action Plans are copied for distribution to all of the meeting participants.

8. **How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and indictors? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

In 2006, Network180 created a Process Improvement Team that included Network180 and provider staff that focused on screening for COD. A similar team was created to look at data collection. After a period of time, it was determined that these teams were interconnected and they began to work in collaboration with one another. The result is the Network180 COD Data Collection Project. A mechanism was developed for collecting data on co-occurring disorders that are identified through the screening process. The mechanism involved a change to the network180 authorization system. A drop down box was added to allow the following designations: (0) Neither Disorder (1) Single Disorder (2) Pre COD (3) COD. The data collection process was piloted at our Access Center, and at two providers sites. The mechanism was added to the network180 authorization screen for voluntary system wide use on October 1, 2006, and was mandated January 1, 2007. This will enable Network180 and system providers to determine the prevalence of co-occurring disorders.

Network180, along with a number of other PIHPs, participated in a consultation provided by the SAMHSA Co-Occurring Center For Excellence (COCE). The consultation was focused on Welcoming, Screening and Data Collection at

access sites. Network180 offered the use of our Data Collection Tool to other PIHPs. The reports from the consultation indicate that the tool was found to be valuable, and may be continued by other PIHPs on a permanent basis.

The Network180 Access Center also received on site consultation from Debbie Tate, the COCE representative regarding consumer involvement (with emphasis on the role of the peer specialist) and welcoming.

9. **What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

As stated previously, participation in the Network180 Date Collection Project became a system requirement on January 1, 2007. There has been discussion regarding practice guidelines for welcoming, assessment, treatment plans, and stage match interventions. A team of provider and Network180 staff has been identified to develop clinical practice guidelines. This work was scheduled to begin in the 2nd quarter. A subgroup of the CCISC Team/Trainers has been formed to address clinical competencies related to COD. The subgroup met on two occasions in the 2nd quarter.

In the 3rd Quarter, the group reviewed the CODECAT, a licensed tool offered by Minkoff and Cline to evaluate clinician competency. The consensus of the group was that the tool was difficult to use. Permission to amend the tool was requested and received. The subgroup met on a number of occasions to make changes, the changes will be submitted to Minkoff and Cline for approval.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how IDDT teams promote practice improvement in the system as a whole.**

Network180 has identified three case management agencies to implement IDDT: Touchstone innovare, Hope Network, and Gerontology Network. Each of these agencies was an active participant in the CCISC initiative prior to their involvement in IDDT. Each of the agencies has signed the Consensus Document 2007. The implementation of IDDT has allowed them to develop a more focused effort that is part of the broader plan to develop co-occurring case ability in their agency.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

Touchstone innovare, Hope Behavioral, and Gerontology Network completed the Fidelity Measure in 2006. Touchstone had a face-to-face consultation with Patrick Boyle in March 2006, and a MiFAST Fidelity Measure in July 2006. Hope Behavioral and Gerontology Network also had consultation with Patrick Boyle. The consultation to Touchstone was funded by DCH, Network180 funded the consultation to the two other agencies.

Touchstone innovare has scheduled a MiFAST review for the 4th Quarter. Additionally, Touchstone participated in a consultation with Patrick Boyle that was funded by SAMHSA on the practice combination of ACT and IDDT (Network180 has a SAMHSA Grant for a program that is based on the ACT/IDDT practice combination).

The other providers are not able to achieve fidelity to the structure of IDDT, but have made progress in terms of implementation of the more clinical aspects of IDDT.

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and core competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g., assessment, treatment planning, motivational interviews), what policies or procedures are in place to make it likely that clinicians will be organized and expected to being to use the training in their work?**

The CCISC curriculum team developed the following training modules for use throughout the Network180 system:

- Welcoming
- Stages of Change
- Introduction to Substance Use Disorders
- Introduction to Mental health Disorders
- Relapse Prevention
- Motivational Interviewing

In 2005, Kathy Sciacca provided a 3 day training for 40 system clinicians and supervisors in the use of Motivational Interviewing. Additionally, 19 of the 40 also received an additional 2 days of training to enable them to train their program staff in Motivational Interviewing. The group developed the 5 two-hour training modules in motivational interviewing highlighted above.

The CCISC Consensus Document 2006 and 2007 offers an incentive for the development and implementation of a training and supervision plan regarding co-occurring disorders. Some providers have used the CODECAT as part of their plan, but it has not been required.

Additionally, all system clinicians who are responsible for requesting authorization from the Network180 system have been trained in the COD Data Collection Project.

Ken Minkoff M.D. and Chris Kline M.D. presented training on the Integrated Longitudinal Strength Based Assessment (ILSA) in December of 2006. This training was open to the CCISC team trainers, as well as additional supervisory/leadership staff.

Network180 received FBG funding to provide training in SUD intervention skills to mental health case mangers. Two training have been held thus far, another is planned for the 4th Quarter.

13. **What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?**

We continue to have difficulty with the apparent contradictions in the scope of practice for bachelor's level staff as defined by the following sources:

- Social Work Licensing Regulations
- Public Health Code

In statewide discussions, it appears that the CMH/PIHPs have made their own attempts to reconcile the contradictions, but in a manner that is not planned or coordinated as a group. It would be helpful if the state could offer some interpretation or direction that we could all follow, so that we aren't all struggling with the same issue, independent of one another.

Network180 has had internal discussions, and requested guidance from the Social Work Licensing Board.

14. **What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?**

The IDDT providers have identified a need for more expertise in the area of Substance Use Disorders. Network180 received a Federal Block Grant to provide training in SUD treatment, interventions, and supervision to all of the case managers and supervisors in the Network180 system; this would include each of the IDDT providers. The training for supervisors was held in May 2007. The first training for case managers was held in June 2007, the second is scheduled for July 2007.

15. **If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?**

There is no need for an amendment.

16. **What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.**

The Network180 EBP IDDT report asks for details of IDDT activity from each of the funded providers. There is an expectation that an action plan will be developed from the IDDT fidelity measures and that action plan will provide service improvement. Network180 will meet with all of the IDDT providers for review of the reports and action plans.

17. **What actions are being taken by the PIHP to sustain this initiative after the block grant period?**

The continuation of the CCISC initiative will help to sustain the gains made through the funding of IDDT programs.

1. **Project Title**: Co-occurring Disorders: Integrated Dual Disorders Treatment
Contract Number: 20071294
Project Number: 20712
Time Period: April 1 – June 30 2007
MDCH Specialist: Tison Thomas

2. **Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team (IPLT). Describe the activities and actions taken by the IPLT to improve the overall system of care.**

The Improving practices Leadership team (IPLT) continues to meet on at least a quarterly basis. The last meeting was held in Baldwin on 6/12/07. The plan is alternate sites between Baldwin, Cadillac, and Traverse City. The IPLT continues to monitor and facilitate implementation of future evidence based, promising, and emerging practices as part of the systems transformation efforts. The Northwest CMH Affiliation is in the implementation phase of IDDT-COD EBP (Evidence Based Practice for adult SPMI and SMI with co-occurring disorder COD). NLCMH currently has one IDDT team on line in the Traverse City office. The WMCMH office plans to begin IDDT services yet this summer and the NLCMH Southeast offices will begin this fall. The Northwest CMH Affiliation continues to work with Dr.'s Minkoff and Cline on the overall systems transformation efforts. Based on the last COFIT, goals were identified and two subgroups of the COFIT Leadership Team were identified and are working on improving Welcoming and Accessibility. The Access workgroup chaired by Josh Snyder has made significant progress. Their progress was reviewed by Ken Minkoff, who provided consultation specific to improving Welcoming and Accessibility. The recommendations have been incorporated into the current work plan and policies and procedures. The Barriers to treatment workgroup is chaired by Joanie Blamer they have met twice and have defined the scope of the issue and are identifying action steps. (ATTACHMENT A)

The Improving Practices Leadership Team (IPLT) continues to serve as a conduit to provide information to the community relative to systems transformation.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHP and CA system, and how is it empowered by system leadership?**

The IPLT has continued to meet quarterly although with the modification of our Affiliation PIHP structure now directly reports to the Joint Leadership Team (JLT) and coordinates with other standing PIHP committees. The JLT is supported in its work by the Joint Executive Team (JET) whose members include Greg Paffhouse, NLCMH CEO, Bill Slavin, Chief Managed Care Officer, and Rich VandenHeuvel, West Michigan Community Mental Health Systems CEO) which meets twice monthly. The JLT meets monthly and its members include staff from both Affiliates and who serve to provide direction, leadership and support to PIHP operations. Current JLT members are: Dave Branding, Bruce Bridges, Julie Burke, Lisa Hotovy, Terri Kelty, Chuck Kopinski, Greg Paffhouse (CEO), Bill Slavin (Chief Managed Care Officer), Emily Smiddy, Rich

VandenHeuvel and Becky Vincent. In addition David Riddle, DO (medical director) serves as an ad hoc JLT member and sits on assigned PIHP committees.

The JLT roles and responsibilities include the following:

- Will address the functions of the systems team to ensure they are being met
- Will reinforce the affiliation structure and PIHP focus
- Ensure resources and support are necessary to support PIHP operations (including evidenced based practice implementation)
- Ensure compliance with BBA Standards
- Ensure the affiliation is prepared for site reviews
- Act on recommendations, approve policies and other items, identify priorities and assign responsibilities

Shown below is the current IPLT membership; which has not changed

Improving Practices Leader	Bill Slavin
Specialist in MI Services	Josh Snyder
Specialist in SED Services	Richard Osburn
Specialist in DD Services	Darryl Goodman
Specialist in SA Services	Dennis Priess
Finance	Lauri Fischer
Data	Chuck Kopinski
Evaluation	Travis Merz
Consumer Employed by PIHP	Nanette Marvin
Family Member of a Child	Jane Sank
Lead for COD	Joe Garrity
Lead for PTMO	Mary Hubbard
Leader for peer-operated services	Ernie Reynolds
Peer Support Specialist	Mary Beth Evans
Family Psychoeducation	Dave Byington
Psychiatrist	Dr. Curt Cummins
Director of QI	David Branding
Clinical Director (WMCMHS)	Emily Smiddy

The IPLT oversees the COD Leadership team. This team consists of Bill Slavin Improving Practices Leader, Joe Garrity Lead for COD, Josh Snyder; Specialist in MI Services from WMCMH, Sue Winters represents the local CA, Northern Michigan Substance Abuse Services (NMSA). Joanie Blamer Emergency Services/Adult Supports Supervisor, from NLCMH SE, has been added to the team. THE COD Leadership Team has compiled and submitted the Block Grant requests as well as quarterly reports. The team has completed a second COFIT and has developed action plans to improve the Welcoming and Accessibility Domains listed in the COFIT. Separate work committees are focusing on these two domains. Josh Snyder is working with the Access/ Welcoming Work group and has made considerable progress (See attachment B), Joanie Blamer is working with the Barriers to Assessment Workgroup. The groiup has meet twice (Attachment C) and narrowed it focus to the COFIT issue that

3. There are no arbitrary barriers to initial emergency mental health evaluation based on substance levels.
4. There are no barriers to psychiatric inpatient admission based upon substance levels, substance diagnosis, or need for

detoxification and there are no barriers to initial routine mental health evaluation based upon presence of substance disorder and/or length of sobriety

Linda Dishman represents the Northwest CMH Affiliation in a COCE demonstration project involving 3 other PIHP's in Michigan.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e.g., welcoming, screening, data collection, etc.).**

The Northwest CMH and Northern Michigan Substance Abuse Services Regional Charter agreement was submitted with the last quarterly report. The document has not changed. However the COD leadership team will work with the Joint Executive Team to develop and disseminate specific COD expectations for staff. The Joint Executive Team has issued a "position paper" that supports the efforts of the IPLT and the COD leadership team. (Attachment D)

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of PIHP/CA service delivery. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

As indicated above, the Barriers workgroup is tackling the Domain II, Accessible. from the COFIT. "There are no arbitrary barriers to initial emergency mental health evaluation based on substance levels."

Heather Flynn PHD meet with the NLCMH Northwest ACT Team, we consulted with her on the barriers issue. She has worked with a group of ER physician who are looking at this issue; we plan to be in communication with them. We have consulted with Dr. Minkoff on this Domain as well. NLCMH Northwest has a jail liaison staff that was trained and worked as a substance abuse counselor. (Anne Baase). She has served on committee's that are looking at jail diversion and reintegration and has worked with Goodwill Inn on substance abuse/reintegration of prisoners into local community. Joe Garrity has represented NLCMH at the local Drug Court.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process? If not, what plans are there to use the tool?**

As stated during the last Quarterly review a COFIT 100 was completed in January of 2006 and redone in January of 2007. The results have been compiled, reviewed with Dr. Minkoff and Dr. Cline, and were forwarded with the last report. Two workgroups are currently focusing on the issue of accessibility and barriers to treatment utilizing the data from the last COFIT. The goal is to develop guidelines for Emergency Service staff, Hospital ER, and Law Enforcement to follow when working with individuals who have COD and may be intoxicated. The central issue is to provide emergency assessments to individuals with COD in crisis without arbitrary limits imposed by blood alcohol levels based on the driver's license parameters.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality development and progress for participating programs? What plans are there for widening program participation?**

The COMPASS tool has been utilized by all contract agencies within the CA (NMSAS) boundary. NLCMH Northwest completed its third Compass and showed a marked improvement from FY 2005-2006. NLCMH SE has completed its first COMPASS. WMCMH has also completed its first COMPASS. The COMPASS has been conducted with participants who are part of the COD leadership team and the clinical leadership team from each agency, The COMPASS is completed in a group setting and consensus is reached on each item prior to moving onto the next item. The results are collected and compiled. They have been analyzed and program objectives have been set to assist quality improvement. Dave Branding, the QA Manager, has compiled the Compass results and has set QA goals for the fiscal year. One of the goals is to collect outcome measures for COD. Joanie Blamer in conjunction with Tom Vinette, Dave Branding Keith Huggett from IT and Joe Garrity modified a data collection form that will be used on a quarterly basis to measure outcome data. The data from the last Quarter is being compiled by Tom Vinette and April Pizzo, the data will not be included with this report but will be included in the next quarterly report.

8. **How has the system organized quality improvement activities related to monitoring improvement and integrated services? What are the targets and indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

The Fidelity Review for NLCMH NW will be repeated this FY during the fall. The results of this review will be compared and contrasted with the initial Fidelity Review. In addition NLCMH SE will have their first Fidelity Readiness Review conducted. WMCMHS will completed a Readiness review with the MI-FAST Team and will schedule a full fidelity review. The results will be compiled and Quality Improvement efforts will be geared towards improving identified performance areas. Currently we are working on implementing outcome data collection for the NLMCH NW office. This form was attached earlier. This will be electronically collected and will be implemented for clients enrolled in the COD –IDDT program as well as during access contacts.

As mentioned last quarter, "The NLCMH QI Plan and Outcome Monitoring Grid were revised at the conclusion of the last fiscal year and approved by the NLCMH Board in December. The grid includes four new measures specific to IDDT including: 1) The percent of IDDT recipients in each stage of change, 2) The percent of IDDT recipients in each stage of treatment, 3) The percent of IDDT recipients in supported employment, and 4) The percent of adults with mental illness and substance abuse receiving IDDT services. These measures will be reported to the QI committee twice annually and the results will be used along with the findings of on-going self-assessments and fidelity reviews to gauge the level of implementation of IDDT as well as to improve the quality of IDDT services being provided." (Attachment F/G)

9. **What policies and procedures have been articulated or are in process regarding clinical practice development that is universal in the system: welcoming, screening,**

assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.

The Leadership Team has developed two workgroups as mentioned in #6. The workgroups have identified the Domains Welcoming and Accessibility from the COFIT and are developing policies and procedures related to these. (Attachment B).
The COD Leadership team developed a set of standards and guidelines for employees working in mental health system that addressed competencies for working with individuals with COD IDDT. (Attachment H)

The Barriers workgroup will modify and submit for approval job descriptions that include IDDT capable an IDDT enhanced standards for employees based on job assignments.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit in to the larger system's movement toward integrated treatment, and how are they supported by their agencies in this process. Describe how the IDDT teams promote practice improvement in the system as a whole.**

The Co-occurring Disorders (COD) PIHP leadership team (subcommittee of the IPLT), consists of members from the IPLT leadership team and has continued to meet monthly. The team includes members Bill Slavin representing the PIHP, Josh Snyder of West Michigan CMHS, Joe Garrity of NLCMH, and Sue Winter representing Northern Michigan Substance Abuse Services (CA). Joanie Blamer from NLCMH SE has been added to the leadership team. She has instrumental in developing the IDDT-COD programs for the NLCMH SE offices. This group has been empowered by the PIHP (affiliation model), the two CMHSPs, and Northern Michigan Substance Abuse Services (CA) to provide direction to our system transformation efforts across the nine counties.

This group reviewed and resubmitted the block grant carry forward funds. The carry forward request has been approved. The NLMCH Outpatient therapy team and NLCMH Act Team has begun staging consumers on a quarterly basis using the stage of treatment format.

We have continued the COFIT Leadership Team, which recently completed the second annual evaluation of the provider network.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MiFAST) fidelity reviews. What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

As indicated above Data has been compiled by the NLCMH NW ACT Team. It is currently being analyzed but will not be ready to include in this report. NLCMH plans to complete its second Fidelity review this September. WMCH had its "pre-readiness survey" and will schedule the full fidelity review. NLCMH NE has scheduled it pre-readiness survey but has not completed this yet. The Northwest CMH Affiliation has included funds in this FY and has requested funding for next FY to support the MiFAST Team. Dave Branding and Josh Snyder are on the MiFAST review team.

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinician scopes of practice and competencies been drafted or are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g. assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?**

Please see the attached FY 07 workplan and time line and Attachment J. Our plans continue to include the following:

- We plan to continue contracting with Dr. Minkoff and Dr. Cline. They will provide ongoing technical assistance to fully implement the Charter Agreement and assist with systems change. Dr. Minkoff did provide feedback to the leadership team and initial training to staff.

- The Northwest Michigan PIHP will continue to contract with Patrick Boyle of the Ohio SAMI to provide IDDT-COD training to both the NLCMH Northwest and NLCMH Southeast ACT Teams. Patrick will also assist in the Fidelity and GOI reviews.

- The Northwest Michigan CMH Afflation had staff trained in Supervisory and Implementation Strategies by Dr. David Mee-Lee in May 2007. Dr. Mee-Lee conducted a one day workshop on the use of Person Centered planning with individuals identified with COD. In addition the NLCMH NW Act team and WMCMH ACT team has participated in phone consultation with Dr. Mee Lee. (Attachment I) It is anticipated we will continue to utilize this service.

- The Northwest Michigan PIHP team leaders visited ongoing COD-IDDT teams in Columbus Ohio to review effective programs and treatment strategies. The team believes this was a very helpful experience and has shared what they learned with the COD IDDT teams.

- The Northwest Michigan CMH Affiliation contracted with Heather Flynn PhD to provide advanced motivational interviewing skills to Clinical staff. Dr. Flynn will engage in ongoing supervision using Videotaped sessions. NLCMH has participated in a consortium to bring national speakers on COD to Northern Michigan.

- The Northwest CMH Affiliation assisted in bringing Claudia Black MSW to Northern Michigan. She presented information on Substance Abuse and Depression. This assisted the Northwest Michigan CMH Affiliation in facilitating collaboration among Mental Health and Substance Abuse systems.

- The Northwest CMH affiliation plans to participate in the DCH sponsored Motivational Interviewing training of trainers under the direction of Michael Clark. The staff to receive this training has been selected.

- Josh Snyder developed a set of Clinical competencies that are attached. The IPLT leadership team has adopted these.

- The Northwest Michigan CMH Affiliation will develop action steps to fully implement these competencies. NLCMH is using the Essential Learning web site www.essentiallearning.net/student to assist in computer based training. One of the courses offered is on COD. Clinical staff will be encouraged to take this course.

- A credential for staff working with COD IDDT will be identified by the credentialing committee and staff will be assisted in working towards achieving this credential

- Job descriptions for NLCMH will be modified to include competencies for COD IDDT capable and enhanced services.

13. What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?

Barriers identified at the last quarterly review are sometimes still experienced. These continue to consist of limited staff times due to expanded case loads and paperwork requirements. The attempt to launch several EBP's at one time seems to conflict and compete with staff time for training. There are a limited number of "experts" available and competing with DCH and other PIHP's for their time creates barriers. Coding modifiers have been addressed and are in the processes of being utilized. The clarifying memo from Patrick Barrie was helpful. Support from DCH appears to be consistent and helpful.

14. What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?

While attitudinal barriers still remain, support from clinicians has begun to emerge. The practice of Staging Consumers for both COD and Mental health concerns seems to assist clinicians in recognizing and incorporating the stages of change in clinical practice. Motivational interviewing is seen as helpful in many areas not just COD. The Barriers Workgroup will work with administration to modify current job descriptions and then work with staff to identify needed training and experience to achieve these competencies. WE could benefit form ongoing team leader tring motivational interviewing trainings and support an encouragement from national leaders and experts.

15. If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?

Implementation and continuation is not problematic. However it is possible that all funds allocated may net be utilized an amendment will be initiated this quarter.

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support the maximum amount of leverage for practice improvement.

Following are ongoing projects:

- Access workgroup and is making changes to the current Clinical Assessment.
- A second workgroup, Barriers, is looking at Accessibility and plans to establish policies and work procedures for emergency assessments that do not impose arbitrary limits based on level of intoxication. This group will develop job descriptions based on the clinical competency guidelines (Attachment H)
- Dr. Mee-Lee will provide ongoing phone consultation.
- Heather Flynn PHD provided initial Motivational Interviewing training to the NLCMH SE staff. She provided advanced as well as supervision to those staff that have been trained in motivational interviewing. Dr. Flynn will provide supervision utilizing taped MI sessions.
- Initial MiFAST fidelity reviews will be scheduled for WMCMH and NLMCH SE. A second MiFAST fidelity review of NLCMH NW will be scheduled for September 2007.
- The Northwest Michigan CMH Affiliation will has been participating in the Michael Clark DCH training of trainers in Motivational Interviewing
- The IPLT and COD leadership team will continue to meet and modify the work plan based on ongoing assessments of progress and need.
- NLCMH has implemented an outcome measures pilot study. Data is being complied and will be reported at the next quarterly review.
- A brochure detailing the COD-IDDT program has been completed for NLCMH and will be completed for WMCM by April Pizzo, who is working on a temporary basis as an administrative assistant (Attachment J)
- The current work plan was updated on 7/10/07 by April Pizzo (Attachment K)
- The NLCMH ACT team will begin a series of peer supervision, utilizing MI techniques. This will include videotaped session that will be reviewed by Heather Flynn PhD.
- A detailed program outline will be compiled that will outline the current state of the COD-IDDT program for the Northwest Michigan CMH Affiation.
- NLCMH plan to apply for a provisional Substance Abuse License with both an Outpatient and Integrated Treatment designation.

West Michigan Progress Summary for 7/20/07

- The ACT team has identified those on current ACT Caseload who are Quadrant IV.

- Each of those identified are being reviewed by the team using the IDDT Bi-monthly Review Team – this includes staging and a baseline on all of the outcome indicators that we are capturing/measuring for IDDT participants.

- After this review, current treatment plans are being reviewed for appropriate stage-wise interventions for both disorders. Changes are made as appropriate.

- We are discussing various options/formats for launching SA groups for both ACT/IDDT consumers and those outside of ACT with SA treatments needs. Goal is to launch groups in September or October.

- An agency-wide training for all clinicians that presents Foundations of Substance Abuse will be presented in the month of September.

- The ACCESS Workgroup recommendations for changes to the assessment process to become more co-occurring friendly are to be implemented in August or September. Changes include preliminary staging for each disorder, Quadrant Model Designation, appropriate SA diagnosing, as well as accurate reporting of codes.

- WM obtained a provisional Substance Abuse License with both an Outpatient and Integrated Treatment designation. We have our first site visit for this on August 23.

17. What actions are being taken by the PIHP to sustain this initiative after the block grant period ends?

The PIHP supports the IPLT and the various project groups; the leadership of the PIHP and the director of NMSAS have completed a position paper (Attachment D) that strongly supports and endorses the COD-IDDT initiative. The COD leadership group will prepare job descriptions for review and acceptance by the IPLT that incorporates the staff competencies that have already been approved by the IPLT and JET. The PIHP continues to provide staff time and resources to implement this project. A culture change has begun and it is expected with the ongoing support of the PIHP that this culture change will grow.

Report Completed by: Joe Garrity
Contact Person: Joseph Garrity or in Joe's absence Bill Slavin
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Michigan Department of Community Health
Mental Health and Substance Abuse Administration
Improving Practices Infrastructure Development Block Grant
Co-occurring Disorder: Integrated Dual Disorders Treatment
Program Narrative
Quarterly Report

1. Report Period	**Period Ending June 30, 2007 – Report Due Date July 31, 2007 – Third Quarter Report FY 2007**
PIHP	**Saginaw County Community Mental Health Authority**
Program Title	**Improving Practices Infrastructure Development Block Grant – Co-Occurring Disorder: Integrated Dual Disorders Treatment**
Executive Director	**Sandra M. Lindsey, CEO**
Address	**500 Hancock Street, Saginaw, MI 48602-4292**
MDCH Specialist	**Tison Thomas & Patricia Degnan**
PCA#	**20715**
Contract#	**20071291**
Federal ID	**38-3192817**

2. **Briefly summarize the Systems Transformation efforts and implementation activities of the Improving Practices Leadership Team. Describe the activities and actions taken by the IPLT to improve the overall system of care.**

The SCCMHA Improving Practices Leadership Team continues to provide overall oversight of all evidence-based practice and related recovery efforts at SCCMHA, including COD/IDDT, DBT, ACT, Supported Employment, and FPE. The Improving Practices Leadership Team meets quarterly now, and met on May 17th. The detail of the implementation of specific practices are addressed in specific practice work group meetings. The FPE workgroup met twice during the period in April and June, and the COD/IDDT workgroup also met twice in April and June. The ACT and SE workgroups are charged with conducting some fidelity review on a periodic basis and this is reported to the IPLT, and both updated their reviews those reviews this quarter as well.

During this period key staff and providers continued to receive additional training. Recovery base measurement was continued at SCCMHA with the involvement o the peer support specialists, and some beginning pre-fidelity consultations occurred with 2 of the 5 COD/IDDT teams.

Recovery themes continue to be promoted throughout the service network this year at SCCMHA, to support IPLT priorities as well as the overall SCCMHA mission and vision.

3. **Describe the structure within the PIHP and collaborating CMHSPs and CAs that are overseeing the systems change process to support integrated services. Specifically identify leadership team members and state how the the leadership team is empowered by the PIHP, CMHSPs, and CAs to oversee the process. What is the level of participation of the CEOs, Medical Directors, and Clinical Directors of each entity? Where does the IPLT fit into the overall structure of the PIHIP and CA system, and how is it empowered by system leadership?**

   The work of the IPLT is integrated into the SCCMHA quality program and is reported routinely to the SCCMHA Management and Service Management Teams as well as the SCCMHA Quality Team. The SCCMHA Quality Team receives monthly reports on the implementation status of EBPs at SCCMHA, including a chronological summary of milestones. IPLT goals are also integrated into the current strategic plan for SCCMHA, which is routinely reviewed by the SCCMHA management team.

   The SCCMHA Medical Director has been involved as much as her time has allowed; she has communicated in writing to the network physicians regarding the COD/IDDT agenda with related notices and EBP and COD/IDDT information.

   Leadership team and specific practice work group members have been identified in previous reports. The CA is represented on both the IPLT and the COD/IDDT workgroup, along with varied substance abuse providers. The SCCMHA Clinical Director continues to serve on the IPLT as well.

4. **Has a consensus document been developed regarding the overall system change? How widespread is participation within the PIHP/CA system? Submit any documents regarding consensus development, policy direction, and chartering of quality improvement activities that have been developed. Identify any overall system priorities that have been adopted (e. g., welcoming, screening, data collection, etc.)**

   Yes, SCCMHA has developed a consensus document; this has been previously submitted to MDCH and has received external endorsement as well locally from varied partners, including the CA advisory board. SCCMHA intends to update this document in the future given some changes in stakeholder representation as well as SCCMHA progress in implementation and the need to include the next wider circle of community stakeholders. SCCMHA expects to update the consensus document in FY 08.

5. **Describe participation and involvement during the past quarter of elements of the system that are not part of the PIHP/CA system. Include consumer and family stakeholders, primary health care and emergency rooms, criminal justice, homeless services, child welfare, etc.**

Consumers, family members, and a health plan representative serve on the IPLT as well as various work groups for specific practices. Some new consumers joined both EBP specific workgroups and the IPL Team this quarter. It is expected that as the DDE and DDC providers progress, SCCMHA will embark upon wider stakeholder active involvement with other community partners, such as the court, etc. as mentioned above.

6. **Has the system done the CO-FIT 100? If so, describe the process, the score, and what action items are being addressed based on that process. If not, what plans are there to use the tool?**

   As mentioned previously, a baseline CO-FIT measure was completed. The score was 197-219 out of a possible 300; the range was based on possible interpretations of some items and soft data in some areas upon which to score. There are no current plans to repeat the measurement at this time; the COD workgroup will consider this in the future upon review of the implementation plan.

7. **How widely has the system implemented the COMPASS? How many programs have done the COMPASS, and how many plan to? Describe the process for doing the tool, collecting the results, and assisting programs in creating quality improvement action plans to move toward DDC. What is the status of the action plan development and progress for participating programs? What plans are there for widening program participation?**

   Three of the five DDE programs have completed the COMPASS; the ACT team has completed it more than once.

   SCCMHA plans for continued movement towards DDE status with the case management programs include specific team leader meetings with IPLT leaders. Two of the teams under the same management structure, have a written implementation plan developed for the program itself, which incorporates not just COD/IDDT, but also FPE and DBT efforts; they meet every other week to review their progress.

8. **How has the system organized quality improvement activities related to monitoring improvement in integrated services? What are the targets and the indicators? Has this been linked with existing PIHP or CA quality improvement activities? How is it connected with consensus priorities listed in question #4 above?**

   SCCMHA is measuring progress by reviewing accomplishments of tasks and goals from the master implementation plan. Since this fiscal year, the key milestones have been captured in a chronological Improving Practices report, an updated version is attached to this report. Consensus document priorities are included in policy and plan detail. Additionally, SCCMHA clinical leadership meets routinely with the adult case management (DDE) program supervisors,

and improving practice updates and information is a standing agenda item for those monthly meetings; this is assisting with the implementation of multiple evidence-based practice implementation in these five team settings.

9. **What policies and procedures have been articulated or are in the process regarding clinical practice development that is universal in the system: welcoming, screening, assessment, treatment planning, stage matching, integrated billing procedures, etc.? Describe the process of development and submit any products.**

   Integrated assessment has been included in the new electronic medical record at SCCMHA for these programs; stage wise additions are being pursued for the progress documentation as well as person-centered planning. A welcoming policy, as well as a DBT and Recovery policy were finalized this quarter. Other policies, including a broad EBP policy, and specific policies for ACT, COD/IDDT and SE - were completed in earlier implementation phases of the project. Coding information has been disseminated to the teams, although implementation of coding is of course subject to the external review and MDCH approval. Three of the five teams have the required substance abuse licensure status at this time.

10. **If you have identified a specific team or teams to implement IDDT, who are they and how were they chosen? Where do they fit into the larger system's movement towards integrated treatment, and how are they supported by their agencies in this process? Describe how the IDDT teams promote practice improvements in the system as a whole.**

    SCCMHA remains committed to having all adult case management programs serving adults with serious mental illness being dual diagnosis enhanced. There are four case management teams and one ACT team in the SCCMHA network. All other key programs that serve this population, as well as programs that serve other populations and the substance abuse provider network members, are expected to be dual diagnosis capable. Each team has its own implementation schedule and process and they have identified barriers that they are addressing.

11. **What activities are in process regarding IDDT team development? Has the Fidelity Scale been used? Did the PIHP utilize or schedule any Michigan Fidelity Assessment and Support Team (MI-FAST) fidelity reviews? What other data collection or performance improvement activities are in process related to the IDDT team? What assistance has been provided by national consultants or others to the team, and what is planned or needed for the coming quarter?**

    During this quarter, training by Michael Clark continued on site at SCCMHA as previously scheduled, in the area of motivational interventions.

Two of the five teams completed a pre-fidelity consultation with representatives from WCHO as well during this quarter, in June, including program level GOI assessment. Three of the five teams will need to complete their pre-fidelity reviews this quarter as currently scheduled.

12. **What activities have been undertaken regarding clinical practice development, both in the system as a whole and for staff in proposed IDDT teams? Have clinicians been widely informed of the process of change and trained in basic principles? Have there been efforts to communicate universal goal of dual competency to all clinicians? Have clinical scopes of practice and core competencies been drafted are in process? What training efforts have taken place? Has the use of the CODECAT been considered or initiated? If there are clinical training goals (e.g. assessment, treatment planning, motivational interviewing), what policies or procedures are in place to make it likely that clinicians will be organized and expected to begin to use the training in their work?**

    There is continued system emphasis to clinicians of the practice expectations and training requirements now embedded in SCCMHA policy, and supervisory support and reinforcement is actively occurring. Dual practice discussion is occurring in team and staff meetings at the program level. Ongoing training, resource information and planning discussions are occurring at team, program and management levels. In May, one of the COD/IDDT team supervisors, who is also the facilitator for the COD/IDDT work group was recognized by SCCMHA for his leadership, and he received the first annual Improving Practices Champion Award.

13. **What administrative barriers from the state have emerged as issues during the last quarter? What efforts have been made to overcome those barriers? What would be helpful at this point from the state to address those barriers? What else would be helpful for the state to provide or do to facilitate your progress?**

    Due to time constraints and multiple role responsibilities of SCCMHA leadership staff assigned to COD/IDDT as well as other EBP implementation tasks, regular attendance at all state meetings has been a challenge, however SCCMHA makes every effort to have representatives participate in each meeting and/or training.

14. **What internal administrative or clinical barriers have you encountered in the last quarter, and what efforts have you made to overcome them? What technical assistance have you received in the past quarter? Are there areas where you feel that you could use specific technical assistance and/or training in the future?**

Potential barriers continue to be clinician time demands and administrative oversight resources. No specific technical assistance needs have been identified at this time. The teams each have identified their own specific barriers and are working to address those issues this year. SCCMHA individuals providing EBP leadership will be meeting with specific team supervisors to offer support and resources as needed. SCCMHA is concerned about the multiple competing priorities impacted these clinical teams; during FY 07 SCCMHA implemented a new IS system which has impacted our time frames for EBP implementation.

It has been somewhat of a challenge to maintain stable consumer representation on work groups at times.

One barrier we experienced this quarter were some scheduling challenges with the trainer/consultant providing MI training. We are working to resolve this issue this coming and final fiscal year quarter.

15. If the project is having problems with implementation/continuation, will all of the allocated resources be needed? Should an amendment be initiated?

It is expected that all allocated resources will be needed at this time.

16. What are the activities and action plans for the next quarter? Describe how project funding is being used in the coming quarter to support maximum amount of leverage for practice improvement?

A. The remaining t hree COD/IDDT teams, including ACT will have their pre-fidelity consultations in August.
B. Fidelity revi ews for all five COD/IDDT teams will be completed.
C. The two remaining teams will obtain their substance abuse licensure.
D. Motivational Interviewing (MI) Training will be completed, with train the trainers planning completed.
E. Recovery trainin g will be completed.
F. Improving Practices Leadership Team will meet in August, and the other work groups will meet July through September as scheduled.
G. EBP leadership persons will be meeting with each specific team supervisors/managers to provide support and consultation on all EBP including COD/IDDT.
H. Publication of the substance abuse EBP guide will be issued.
I. The Improving Practices Leadership Team will discuss use and implementation of the EBP attitude scale this quarter.
J. Additional staff/provider FPE training and implementation of family groups will occur this quarter.

17. What actions are being taken by the PIHIP to sustain this initiative after the block grant period ends?

Policy and procedure integration, electronic medical record installation that includes integrated treatment formats, and supervisory and administrative oversight of practice implementation, as developed and to be refined as needed, will support sustainability. The SCCMHA Quality Team and the Case Management Supervisors Meeting are both venues where the EBP practice updates and goal setting will continue over the long term.

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COD - Initiative
Quarterly Narrative Report
3rd Quarter
FY 2007 April 1, 2007 – June 30, 2007

1. COD Initiative
PCA #06-20716
Contract: #20071342
3rd Quarter / FY 2007 April 1, 2007 through June 30, 2007
Karen Cashen

2. The Thumb Alliance PIHP's Improving Practices Leadership Council (IPLC) continues to provide system level oversight to the IDDT tool kit implementation process. As regional action planning in response to the IDDT baseline fidelity assessment progresses, the IPLC anticipates the need to address region wide barriers to increased model adherence and will act as a conduit to the Thumb Alliance Management Council.

In addition, the IPLC continues to oversee additional key clinical practices. The Thumb Alliance now has an endorsed and functioning regional Recovery Workgroup to provide direction to the system as we move towards the creation of a true Recovery focused environment. The Lapeer CMHSP has also begun to undertake implementation of the Family Psych-Education Tool Kit, and is reporting on the progress of that endeavor to the IPLC. The IPLC is also evaluating potential additional EBPs for system-wide implementation.

The IPLC also served as the PIHP committee for reviewing and recommending endorsement for all adult and children's block grant requests from the Thumb Alliance PIHP region. The recovery Workgroup, a sub group of the IPLC, completed a Recovery Environment Assessment on each of the adult requests.

3. The Thumb Alliance PIHP is working towards formal integration of the public mental health and substance use systems concurrent to the efforts to implement the IDDT tool kit. Both the PIHP Board, and the governing St. Clair County CMH Board have endorsed the movement of St. Clair County CMH towards formal designation as the regional Coordinating Agency. The necessary formal waiver requests and request for designation as the regional CA have been approved by both boards and have been approved by MDCH as well. The Thumb Alliance PIHP will be designated as the regional CA effective 10/1/07. The Thumb Alliance Management Council has taken leadership in the CA transition activities, with all three CMHSP Directors (who are standing members of the Management Council) taking lead with their local county Board of Commissioners to ensure appropriate education and to request endorsement. The Management Council has formed, via the PIHP a CA Transition Workgroup to implement the transition plan. The Chief Operating Officer (COO) of the PIHP chairs that group, which also consists of the current CA Director, the PIHP Chief Clinical Officer (CCO), and key administrative leadership staff in the areas of IS, QI, Data Management, Fiscal, and Contract Management. In addition, lead PIHP

staff have been meeting with staff from ODCP to prepare for a successful transition.

There is significant crossover between that group and the two primary groups related to the implementation of the IDDT Tool Kit (the IPLC and its sub work group, the Co-Occurring Disorders Workgroup). The IPLC is chaired by the PIHP Medical Director. The COO and CCO of the PIHP are members of both the IPLC and the COD Workgroup, as is the CA Director and the QI/Data Management Director from the PIHP. Clinical Leadership representatives from the three Thumb Alliance CSSNs are also members of both the IPLC and the COD Workgroup. All of these groups report to the Thumb Alliance PIHP Management Council.

In addition, the Thumb Alliance PIHP has taken lead on the implementation of the required Strategic Prevention Framework/State Incentive Grant (SPF/SIG) initiative for the Thumb Region via a contractual relationship with the outgoing CA (operated via the St. Clair County Health Department).

4. The Thumb Alliance PIHP has developed and previously submitted two documents related to system transformation. The Thumb Alliance revised its Vision statement in the last fiscal year to better capture its goals and efforts towards system transformation and is in the process of reviewing and revising that vision as part of a continuous quality improvement process. In addition, the Management Council and the applicable Boards endorsed a Charter document created by the IPLC to guide its efforts in the system transformation process.

   The Thumb Alliance PIHP has not as yet created formal consensus agreement documents with the provider network system.

   Welcoming and Integrated Screening are two topics that are currently being addressed by the PIHP within the IPLC construct. The PIHP has revised its system wide policy on access to ensure it is appropriate to all populations we serve. Among the changes made is the incorporation of the concept of welcoming throughout the process. We are also continuing to work with Wayne State University and participating with the COCE project to explore the concept of integrated and standardized screening throughout the Thumb Alliance region.

5. Much of the energy over this past quarter was directed at the implementation of the IDDT fidelity action plans, created in response to our baseline IDDT/GOI fidelity assessment. We have recently received correspondence from MDCH regarding the necessary participation with MI-FAST for ongoing fidelity assessment (we had contracted directly with WSU and formed our own fidelity assessment review team) and have begun communications regarding integrating that process with ours. We have not had high level involvement of those systems external to the PIHP/CA system throughout this quarter.

6. The Thumb Alliance PIHP did complete the CO-FIT 100 last fiscal year. We administered the CO-FIT 100 to a group that included our Management Council

as well as our IPLC. As a region, we scored 154/500 on the CO-FIT 100. As we analyzed the results of that process, we struggled to be able to use the results for the development of a work plan with any specific tasks. The tool and resulting data was too global and general, in our opinion. As we consulted with Wayne State University regarding our results and next steps, we made the decision to move ahead with the IDDT/GOI baseline evaluations and to table use of the CO-FIT 100 for future discussion should the IDDT/GOI process not yield positive outcomes for the system.

7. We have not implemented the COMPASS to date. We are focusing on the IDDT/GOI fidelity assessment process at this time.

8. The Thumb Alliance PIHP has begun to organize QI activities related to this initiative. Under the leadership of our QI/Data Management Division, we continue to show significant improvements in our conscientious reporting of demographic data describing the prevalence of COD within the public mental health SMI population. We have also begun work revising policies to reflect necessary system attention to co-occurring disorders, including our access policy and our credentialing and privileging policy. In addition, we are in the process of finalizing a Waiting List Policy as we prepare for CA designation. We have formed a sub-group to evaluate our screening protocol and process (both at the front door and within the treatment continuum) and will examine the potential benefits of using standardized integrated tools throughout the system. The Thumb Alliance PIHP is in the process of moving to a new software system (PCE) and has used this as an opportunity to refocus on integrated screening.

   The Thumb Alliance PIHP has also implemented an aggressive training protocol related to system competency to treat individuals with COD. We are nearly through a yearlong plan involving Wayne State University that has provided us with training in the areas of:
   - Understanding IDDT;
   - Motivational Interviewing – including formal training, coaching, and scoring of taped sessions;
   - Stage-Wise Intervention;
   - Pharmacology and COD for medical and non-medical providers;
   - Understanding Addiction;
   - Screening, Assessment, Diagnosis, of SUD in the SMI Population; and,
   - Clinical Treatment of SUD for individuals with SMI.

   The Thumb Alliance is working with WSU to make available CEUs and CMEs for as many courses as possible in this curriculum.

   The feedback we have received from staff related to these trainings has been overwhelmingly positive, in fact, our medical professionals requested (and we provided) a second session on pharmacology via WSU. We are working with Wayne State University to create training modules in some of these areas for future use as introductory or refresher trainings.

9. The Thumb Alliance PIHP has revised its policies on Access and Credentialing and Privileging. We anticipate more significant policy development and revision to needs to be articulated via the local action planning processes that are now being initiated in response to our baseline IDDT/GOI fidelity assessment process. The process we use for these initiatives will likely vary based upon the type of policy that requires either revision or development. All recommendations and actions in this area will come via the regional COD workgroup. The PIHP is beginning the development of a new training policy, and has included IDDT training opportunities on the regional training grid.

10. Each CSSN has formed a local action plan development team with representation from the direct service providers (including peer support staff), key agency decision makers, agency QI staff, and program leadership staff. These groups have taken lead in developing and implementing local action strategies regarding IDDT implementation. The plans have been shared at the COD Workgroup level and at the IPLC level. The COD workgroup is serving as a consultative body in this process, allowing for sharing of ideas and resources, and promoting consistency in how we understand results of the assessments and move forward towards increased adherence to the model.

11. See above in regards to activities underway. Our baseline IDDT/GOI fidelity assessment was completed in the first quarter of this fiscal year. We have been contracting with WSU from the outset on this process. The Thumb Alliance PIHP opted to create its own team and contract with WSU for leadership and consultation. Our team was co-lead by an experienced WSU evaluator and our clinical analyst, a PhD. Psychologist who has received training in this process via Patrick Boyle (training and shadowing) and WSU. Our team included primarily PIHP staff. One unique quality of our evaluation team relative to MI-FAST and other evaluation teams we have seen/heard about, is that the Thumb Alliance PIHP elected, from the onset, to include a peer support staff as a full member of the evaluation team. We believe this has allowed us to look at our regional programs and policies with a more complete perspective and has definitely added value to the process. Although the IPLC recently reconsidered the option of formally joining the MI-FAST group relative to the evaluation process and elected (unanimously) to continue with our established process, we have subsequently received notification from MDCH that participation with MI-FAST will be mandatory and are in the beginning stages of developing a plan to transition.

    The Thumb Alliance has been represented at training and consultation provided by Patrick Boyle, as well as the Minkoff/Cline trainings. In addition, we have had a staff member shadow one of Patrick Boyle's review teams in Ohio, we have contracted separately for IDDT/GOI training from WSU, and we have participated with MI-FAST (except for the fact that we had not actually been receiving or providing evaluation services via that group).

12. We have not used the CODECAT system wide to date. As we referenced earlier, however, we have initiated an aggressive training protocol this fiscal year that

targets a wide variety of staff. Among the objectives of this protocol are to increase the system level awareness of our transformation efforts related to IDDT, to increase the understanding of the IDDT tool kit, and to increase staff knowledge and competency in the identification and treatment of co-occurring disorders.

In addition, the IPLC has, within its current QI plan, identified review and revision of the PIHP clinical protocols as a current targeted task.

13. The Thumb Alliance has not identified any new barriers this quarter. The barriers identified previously still seem to exist, however, including but not limited to:
    - Lack of integration between the Mental Health and SUD bureaus of MDCH, which seems to cause an inability to make decisions/policy calls that may impact both the MH and SUD systems expediently at the state level;
    - Differences in policies/rules/practices related to confidentiality, recipient rights, ability to pay, etc.; and,
    - The use of language in licensing rules that causes provider level confusion regarding licensed integrated treatment and the IDDT tool kit implementation.

14. The Thumb Alliance has not encountered any new barriers over this third quarter. We anticipate that the ongoing development of local action plans will bring local and regional implementation barriers to the surface.

15. We have submitted (previously) an amendment with a request to carry forward funds from year one. This need was primarily caused by the baseline fidelity assessment process needing to be continued into the beginning of this fiscal year and our agreement to reimburse WSU for their assistance with this process at the point of completion.

16. The primary activities for this coming quarter are in the areas of local action plan implementation and oversight, policy revision and development (including exploration of the use of standardized integrated screening tools), staff training and curriculum development (in consultation with WSU), and continued participation with state level efforts related to system transformation. The Thumb Alliance PIHP CCO is involved in all of these efforts and we will continue to access WSU for consultation and assistance in the implementation process.

17. The Thumb Alliance created the IPLC with the intent of continuing system transformation efforts beyond the terms of the block grant. It is a group and function that has become embedded within the PIHP structure. In addition, the PIHP is working towards creating training modules based upon the curriculum developed with WSU that will be used as refresher material for existing staff and as orientation/training material for future new staff. The training modules will be placed in our online library and will be updated as necessary.